

THE ROLE OF A FACILITATOR IN  
ENABLING REGISTERED NURSES TO  
TRANSLATE REFLECTIVE APPRAISAL INTO  
WORK-BASED LEARNING AND AN  
EVALUATION OF THE OUTCOMES OF THIS  
LEARNING

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## **Abstract**

This research set out to develop a detailed understanding of the role of the facilitator in enabling registered nurses to translate reflective appraisal into work-based learning (WBL). In doing so the research identified contextual issues that impact on WBL, facilitative processes that enable WBL, and outcomes from WBL.

A person-centred, action-oriented, participative methodology was developed specifically for this study. It combined a conceptual framework for facilitation (Critical Companionship) with constructs for a critical enquiry. The methodology was operationalised through two year-long action cycles. In each cycle a facilitator/researcher worked in a 1:1 relationship with five registered nurses to facilitate their learning. Each 1:1 session was audio recorded, and a reflective process review was completed.

Three times in each action cycle the participants and facilitator/researcher met up as a group to undertake data analysis using a creative reflective approach. The outputs from this were themed by the facilitator/researcher, and the resultant themes and sub-themes were illustrated with extracts from the 1:1 sessions. A reflective synthesis of each theme enabled the development of a model for a Professional Learning Partnership.

A Professional Learning Partnership contains a facilitation triad that requires a trusting partnership; activities to maintain stability; and activities to stimulate growth. The facilitation takes place during a professional conversation in a safe space in work. The contextual factors that impact on the learner are their commitment, how safe they feel in work; and how able they are to act. The outcomes for the learners are changes to self, a changed way of being, and professional growth. These lead on to changes to individual practice.

This research has added a new methodology to the field of person-centred healthcare research, and a model for a Professional Learning Partnership that contributes to understanding how a facilitator can enable nurses to learn through their work.

**Key Words:** Facilitation; Work-based learning; Professional learning; Person-centred research; Action-oriented methodology;



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## **Dedication**

*To Mum and Dad*

Robert Kemp 1930 – 1989

Sonia Kemp 1934 – 1994

**Morgan.**

*Morgan, I have been working on this thesis for almost a third of our married life. Throughout this time, you have never complained and never once doubted that I could succeed. Only once did you question the wisdom of my continuing, and that was when I was unwell. I couldn't have done this without your endless love, patience, and support, not to mention the continuous flow of coffee and Kit-Kats as I raced to finish. I will always love you.*

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# **Chapter 1 – Introduction**

## **Introduction**

I started work on this thesis almost 10 years ago. In that time my life like everyone's, has had its ups and downs. I am also a registered nurse and that means that in the midst of living my life I also work and learn. Supporting learning in work has engaged me for the last 30yrs of my career. It always comes about however that just when you think you have things sorted a 'banana skin' appears from somewhere and turns your world upside down. For me that 'banana skin' was facilitation.

I will start my thesis by laying out the problem that I had come up against and the question that started me on this research path. This chapter continues with setting myself into context by telling the story of how my career and my mode of teaching and learning have changed up to this point. My thesis will then develop over the course of a further eight chapters where I will describe in detail how I worked in collaboration with ten practitioners to develop new knowledge about the facilitation of work-based learning. It ends by showing how I have synthesised this knowledge into a model for a professional learning partnership that has already started to help other practitioners to facilitate work-based learning.

## **The Background**

This thesis set out to address the problem of 'how to make it work'. The 'it' in question was an integrated professional and practice development framework that was developed in the Royal Hospitals Trust Belfast (now Belfast Health and Social Care Trust) in 2002 (McCormack, Devlin & McIlrath, 2004). The idea behind the REACH programme (as it was known) was to support nurses to generate and accumulate knowledge for themselves based on their everyday practice, and then with the help of a facilitator to critically consider this knowledge and the way they were implementing it in practice (Appendix 1). The plan was that this would address the needs of nurses as adult learners, provide links between academic and experiential learning, and

translate learning into practice. The REACH programme had been introduced into Wales in 2007, and despite a lot of effort we were having difficulties in realising its potential. Nurses in the programme were becoming aware things needed to change either in themselves or their practice, but then they stopped and appeared unable to move on to do something about it. I had gone to Belfast to seek advice on where we were going wrong and what we could do differently to 'make it work'. Following discussions and reviewing the findings from evaluations of the pilot projects in both Belfast and Wales the key difference seemed to be the presence of facilitators in some of the areas in Belfast. However, exactly what these facilitators did to make a difference to the practitioners was unknown. This was the start of my journey and became the focus of this thesis.

## **A Journey from Teacher to Facilitator**

I have been a registered nurse since 1984. My nurse training took place in one of the big 'teaching hospitals' in London following a classical apprenticeship model. We had clinical lectures that were delivered by medical consultants, and we learned clinical practice by working on the wards, mainly being guided by student nurses one year ahead of us. At the end of three years my 'Hospital' exams earned me my hospital badge, and my 'State' exams got me onto the UKCC Register and entitled me to wear the navy belt and buckle of a registered nurse.

I worked as a staff nurse in my training hospital for two years before moving further north in England to undertake an English National Board (ENB) clinical course in Accident & Emergency (A&E) Nursing (ENB199) in what was then the largest A&E department in the country. The teaching I experienced on this course had evolved but was still mostly experiential (being on the course meant being employed as a staff nurse in the A&E department). A mixture of nursing and medical staff delivered clinical lectures and we had a large number of clinical expectations that had to be 'signed off'. The course assessment strategy included writing 'assignments', and this was the first time that I had really engaged with peer-reviewed journals rather than text-books as the source of my knowledge.

In 1987 at the end of the course I moved to Wales to get married, be a farmer's wife and never nurse again. However, three years later after having two sons, I went back to work. I started two nights a week in the local nursing home, then moving to 30hrs a week in the local Cottage Hospital, before taking up a post as a staff nurse in 'Casualty' in the closest district general hospital to home, which was 25 miles away. I discovered that nursing here was 10 or more years behind the large A&Es in England. Specialist practice that was 'normal' when I did my ENB199 in 1986/7 had not yet reached this corner of West Wales. It was therefore circumstance that led me into teaching as I tried hard to modernise emergency nursing practice. It was at this time that I also started to experience people who didn't want to change, who perceived me as a threat to their way of working, and who consequently made work difficult. A new Director of Nursing changed things. I was supported to introduce a system of triage into A&E. I was introduced to the Chief Nursing Office for Wales as a 'rising star', and I also became a Junior Sister and was therefore in a better position to continue to teach and modernise. I had invested in my own career and undertaken the Advanced Trauma Nursing Course, Advanced Life Support Course, Advanced Paediatric Life Support Course, and the Emergency Management of Severe Burns course, and I had been invited back to be an instructor for them all. I had also done a Diploma in Nursing and an MSc. I had developed myself into the 'expert'. I was aiming for a Consultant Nurse post and I was more than happy to share my knowledge across the department.

At the start of the journey into this research my Consultant Nurse ambitions had reached a dead end due to a lack of opportunity. I had been the department senior sister but was now the practice development nurse. My role was to plan and deliver the education required by registered nurses working in the unit and keep a wider eye on developments within emergency nursing across the country to ensure the unit remained up to date. My educational plan was simply to ensure that the nurses were taught the clinical skills and knowledge that was directly relevant to their practice. I was in control of deciding what was taught, and my own expert knowledge of emergency nursing was essential to this. In general, my teaching was task orientated to ensure staff achieved their practical competencies so that I too could demonstrate that I was meeting my targets. My way of working was twofold. Firstly, to take the nurses out of the clinical area and teach them in a classroom and secondly, to work alongside them

in practice assessing their competence in various extended roles. The registered nurses I worked with were quite happy to wait for me to organise a study session or workshop, produce packs of all the theoretical knowledge to support that session, and set up competency frameworks to assess their knowledge and skills in practice after the teaching. I was quite happy to be the expert who ‘passed on my knowledge’ and the person that everyone came to with questions. It gave me great satisfaction and pride to hear nurses say, ‘Caroline taught me everything I know’.

My previous learning experiences, as well as the positivist stance that is reinforced as the gold standard almost everywhere in healthcare, had influenced my teaching up to this point. This positivist stance believes that truth exists regardless of what an individual may believe. This means that there is an objective and reliable set of facts, principles, and theories that are supported by scientific research and lead to one defined way of performing skills and one defined strand of knowledge. I worked hard to pass on this ‘evidence-based’ knowledge and skills to the nurses in the unit. What I didn’t realise however was that I was effectively disempowering them as I was doing little to develop them into critical thinking, autonomous practitioners, and was instead making them even more dependent on me for their source of knowledge. This came back to bite me when everyone looked to me to provide the counter argument against a management imposed new way of working that we all felt was inappropriate for our environment, and worsened care for some of our patients. Being the visible face of opposition in a management-led, target-driven culture took its toll on me and I ended up burnt-out and off sick.

### **The REACH framework.**

My return to work coincided with the introduction of the work-based learning programme (REACH) into the Hospital. The framework consisted of 27 attributes (later reduced to 12), each of which contained four levels (advanced beginner, competent, proficient, and expert) (Appendix 1). In each level there were discriminators that helped the practitioner to identify at which level they were currently working. The practitioner was expected to undertake a reflective self-assessment against the attributes and discuss this at their appraisal. From the appraisal, the



practitioner would decide on two or three attributes to develop in the coming year and would then write a learning contract to direct their learning. The practitioners would be supported with their learning by a work-based facilitator and would compile a portfolio of evidence of their learning. There was the option for nurses to register with the University of Ulster (later taken over by Swansea University) and have their work and the associated portfolio academically accredited.

### **Main findings from Evaluation 1a and 1b - Belfast**

The REACH framework was initially implemented in the Royal Hospitals Trust, Belfast in two pilot studies. Both pilot studies were extensively evaluated using the theoretical framework of ‘realistic evaluation’ (Pawson, Tilley, 1997), and recommendations were made to inform the future roll out (McCormack, Devlin & McIlrath, 2004, Boomer, Devlin & McCormack, 2006).

The focus of the evaluations of Pilot 1a and Pilot 1b was on describing the mechanisms, the contextual issues that impact on the mechanisms, and the areas for potential outcome measurement in the next phase (Boomer, Devlin & McCormack, 2006). From the pilot studies three mechanisms were identified that were considered important, which included:

- Reflection – reflection in and on practice is fundamental to developing critical thinking and expertise in practice
- Facilitation – to enable reflection and the development of reflective practitioners, effective facilitation was critical.
- Evidence – the use and integration of evidence into practice and the development of evidence from practice development.

It had not been the intention of the evaluation to identify the outcomes of the project, however, there were some outcomes that were evident even from the pilots (Boomer, Devlin & McCormack, 2006). Key amongst these was the fact that in those areas where there was a high level of skilled facilitation the project and the practitioners flourished.

## **REACH in Wales**

It was the framework that was adapted as a result of the Belfast pilot studies that was brought to Wales in the summer of 2007. An NHS Trust (now part of the University Health Board), in partnership with Belfast Health and Social Care Trust and the Royal College of Nursing (Wales) agreed to undertake a pilot study of the REACH programme. Phase one of the Wales pilot involved one hundred and forty-four registered nurses from two intensive care units, one high dependency unit and two accident & emergency departments spread over two hospital sites. Forty-one of the registered nurses attended the 'Facilitating Personal Development' two-day course to become appraisers. Twenty-seven participated in the 'Facilitation and Leadership in Developing Practice' module, which was a six-day course spread over twelve weeks and designed to develop facilitators. Both courses were delivered 'in house' by nursing development facilitators from Belfast, who also introduced us to the use of the creative arts as a way to support reflection, learning and the development of new knowledge.

My role in the REACH project was to be a work-based facilitator for some of the registered nurses participating in the programme in the emergency unit. A lot of hard work was invested in getting the attributes framework embedded as a basis for a critically reflective appraisal, and figures from the clinical areas showed that the appraisal rate rose to 98%. Despite this apparent success it was proving difficult to get beyond this point. As mentioned in the introduction we were helping nurses to become aware that there were things that they needed to change, either in themselves or their practice, but helping them to move on from this awareness and into action was where we were stuck.

The evaluation of the pilot in Wales was undertaken by the RCN (Wales). Despite the findings of a reported increase in levels of reflection and a wide range of learning opportunities being identified, there was limited evidence of the learning being related to, or making a difference to, patient care. The key finding that related to the findings from the Belfast evaluations was that in Wales over half the nurses interviewed either had no support from the facilitators or didn't know who their facilitators were (Bailey, 2009). Taking into consideration the evidence from the pilot studies in Belfast and

Wales, the seemingly obvious reason for our lack of progress was that we just didn't have the expertise to facilitate this work-based learning.

### **The impact of the REACH project on me personally**

The REACH project was my first conscious engagement with facilitation, and it was unsettling. I had taken over as project lead about six months into the two-year pilot, and as the project manager I was encouraged to undertake the Post-Graduate Certificate in Facilitation and Life-Long Learning. This was a year-long distance-learning course with the University of Ulster. The intention behind putting me on the course was so that I could, in time, support other nurses to develop their facilitation skills. I had just completed a Post Graduate Certificate in Education to validate my teaching skills and had vowed never to do another academic course, but facilitation was a new challenge and I couldn't resist.

Everything I read about the use of facilitation talked about the need for expertise, but I knew that this was one thing I didn't have. I was so uncomfortable in my position as a novice that all I wanted to do was develop my facilitation skills quickly so that I could once more be the expert and start to 'teach' other people about facilitation. I went in search of a short cut and fell back into my normal way of learning, which was to read 'the evidence'. I started to look for the 'recipe book' or the 'how-to' manual. I believed that if I just read and read until I understood this thing called facilitation, I would simply be able to put it into action. I had never really considered that what I believed about knowledge impacted on how I was both approaching my own learning as well as how I was supporting my colleagues to learn. I failed to appreciate that developing understandings from my own experiences was also legitimate knowledge. This constructivist position believes knowledge is essentially subjective, intuitive, and reflective, and takes influence from everything around. I knew about 'experience' and 'intuition' and had cause to fall back on it many times throughout my career, but like many others I didn't know how to actively develop this knowledge so that I could use it to its full potential.

It was at this point that I realised that if I wanted to develop as a facilitator I had to completely rework my approach to learning, my understanding of different forms of legitimate knowledge, and most importantly change my relationship with those I was

helping to learn. It was a long, slow, painful process as I passed through a process of unlearning (Macdonald, 2002, Raab, 1997) towards new ways of working and got to grips with the inevitable feelings of a loss of control.

*A week ago, I felt as if I was on the edge of something momentous. I felt that I just needed to be brave and step off the cliff so that I could fly. I didn't think it would be easy, I expected to dip a bit as you would before you started to fly, but I felt that with a bit of effort I could do it.*

*Well I have stepped off and now I'm in freefall....*

*[Reflective Diary: Oct 08]*

## **Changing my ideas about learning**

Learning is a complex behaviour that can involve how we think, feel or do something. Many times through the course of this research I have asked myself 'what is learning?'. The definition that I now use is this one.

“the process of developing knowledge, skills or new insights, bringing about a change in understanding, perspective, or the way something is done or acted upon” (Nisbet, Lincoln & Dunn, 2013 p469)

Widening my understanding around learning has involved looking at many different ideas, including using the creative arts. Creative work is felt to be a useful way to uncover the store of tacit knowledge that we all have inside us, with the idea being that using creative art helps us to articulate things that we may otherwise find difficult (Titchen, 2004). Engaging with creative work has enabled me to look at things with a more open frame of mind, and I now use the creative arts to help to develop my understanding, to work through difficult concepts and to crystallise ideas. Various examples of my creative work are included in this thesis.

## **Reflexive vs Non-reflexive Learning**

My understanding of the way people are helped to learn has crystallised down into two main forms. Although there are a variety of names for these forms of education, in essence they all separate learning / education into two main types.

The first type of learning, often referred to as non-reflexive or ‘banking’ education, usually occurs through a one-way process when knowledge is transferred from an expert to a learner, who accepts it and memorises it without question. The learner is then expected to apply that knowledge in standard situations. This is the type of learning that I was expecting the nurses to do when I was working as their Practice Development Nurse and teaching them about emergency nursing. It was also the type of learning that I was planning to do as I learned how to be a facilitator. The second type of learning, referred to as reflexive or ‘critical’ education, is where the learners are helped to generate or accumulate knowledge for themselves. They are then expected to consider the knowledge through a dialogue with self and / or others and accept or reject it based on the results of the discussion.

A number of learning theorists have contributed ideas that have helped to delineate these two main types, but in particular they have helped to develop the critical / reflexive type. The first person who is credited with identifying that there were two approaches to learning was Plutarch, a Greek philosopher who lived from 50-120 AD. His view was that ‘the correct analogy for the mind is not a vessel that needs filling, but wood that needs igniting’. It was Paulo Freire however who first used the phrase ‘banking’ education, and his contribution to adult education is based on the difference between this mechanical build-up of knowledge, and the active participative acquiring of knowledge, related to the lived experience of the learner (Freire, 1996). Freire believed that critical education is never a simple transmission of knowledge. He saw it as gaining knowledge through active participation, critically considering that knowledge, and then if necessary changing the understanding or changing the context from which that knowledge arose (Freire, 1996).

Viall also suggests two forms of learning that have considerable similarities to Freire. These are ‘helping the learner to find his/her way to the knowledge’ as opposed to ‘transmitting the pre-existing stock of knowledge’ (Vaill, 1996 p192). Mezirow (1981) based his theory of transformative learning on Habermas’ theory of Communicative Action (Habermas, 1984). He believed that learning from practice should involve not just reflection, but critical reflection. This challenges learners to question previously held assumptions and beliefs that are then examined, discussed, and tested, potentially leading to new insights.

In all of these learning theories the key issue is the one-way transmission of knowledge in the non-reflexive learning, as opposed to the two-way, discursive growth of knowledge in the reflexive learning. It was the two-way discursive learning that I engaged with in the PGCert in Facilitation and Life-long Learning that became truly transformational for me. It was this that I was hoping to use to facilitate the REACH programme and support learning in the workplace. Still being something of a novice however, I was unsure what that facilitation should look like, and it was this question that led directly to the research study.

## **Research Aim and Research Questions**

### **Aim:-**

To develop a detailed understanding of the role of the facilitator in enabling registered nurses to translate reflective appraisal into work-based learning, and an evaluation of the outcomes of this learning

### **Questions:-**

1. What contextual factors help or hinder work-based learning?
2. What facilitative processes enable meaningful work-based learning?
3. What are the outcomes arising from facilitated work-based learning?

## **Overview of the Thesis**

This thesis sets out to describe the planning for the study, the study itself, analysis of the resultant data, and a discussion of the findings including the implications for practice. It is structured over nine chapters and has examples of my creative work throughout, in the hope that they may help others to understand my thinking.

**Chapter 1** is this chapter and sets out the background to the study, placing it into context. The chapter explains about the REACH programme, and how engaging with

the programme helped to develop my understanding of knowledge and reframe my approach to helping others to learn. The chapter ends by explaining how my attempts to ‘make REACH work’ led directly to this research study.

**Chapter 2** is a narrative review of the empirical evidence around work-based learning and facilitation. It sets out the strategy used to focus the review so that it provides both a backdrop to the study as well as an overview of the current state of knowledge about work-based learning and facilitation. The chapter concludes by reviewing six existing frameworks for facilitation.

**Chapter 3** sets out the philosophical underpinning for the study, which is humanistic existentialism, hermeneutics and critical theory. It looks at how the philosophy was used to provide direction for the methodology, as well as the learning processes used in the study

**Chapter 4** looks at the development of the methodology, which is based on the Critical Companionship facilitation framework. It moves on to show how the methodology was brought to life. It describes the ethical implications of undertaking the study and the safeguards that were put in place. An overview of the recruitment process is provided, and the practitioners are introduced. The chapter moves on to describe the learning methods, facilitation methods and data analysis methods that were used in the study. The chapter ends with an audit trail of the data analysis process.

**Chapter 5** is the findings. The 4 themes and 19 sub-themes are described and then illustrated using extracts from the one-to-one meetings between the practitioners and the facilitator. Each theme ends with a reflective synthesis. The final part of the findings is the presentation of a model of a Professional Learning Partnership, which encapsulates our understanding of the role of the facilitator in work-based learning

**Chapter 6** discusses the model developed from the findings, and the key issues that arise from this. These issues are positioned within the existing literature, and the new knowledge developed through the study is articulated.

**Chapter 7** is a reflexive review of the study. This reflexivity considers the study from 3 angles, a) Introspective, considering my position in the study as both research and facilitator and the impact of this on the study b) relational, considering the impact of the relationship between me and the practitioners on the study c) epistemic,

considering the impact of the methodology on the generation of knowledge through the study

**Chapter 8** puts the findings from the study back into context and considers how it could be implemented into practice.

**Chapter 9** contains the conclusions that I have drawn from the study and the knowledge generated through it. It also makes recommendations for further study.

## **Summary**

This chapter has provided a frame for the research. I described my differing experiences of learning throughout my career, and how I serendipitously ended up teaching. My understanding about learning and knowledge development was influencing my approach to teaching. It was only when I was introduced to the idea of facilitation that I had a transformative change in that approach.

Facilitation came into my life as part of the REACH project, which was introduced to encourage the change from non-reflexive learning in a classroom to reflexive learning in the workplace. Evaluations of the pilot studies in Northern Ireland identified that in those areas where there were experienced facilitators the project and practitioners flourished, although the exact role of those facilitators was not made explicit. In contrast the evaluation of the pilot project in Wales showed that over half the nurses had never met their facilitator or didn't know who their facilitator was. This research study and the associated research questions arose directly from these observations. The following chapter will review the literature in order to develop an understanding of the existing knowledge around work-based learning and facilitation.



# **Chapter 2 – Work-based Learning & Facilitation**

## **Introduction**

This chapter provides a narrative review of the existing evidence around work-based learning (WBL) and facilitation in order to develop an understanding of the topics and inform the development of the research. The topics of learning, work, and facilitation are very large, so focusing the literature review was essential. Initially my aim was to consider just literature that referred to the ‘facilitation of work-based learning’, however this was very limited and missed a considerable amount of the facilitation literature that I already knew was available. I therefore made the decision to search for and review the topics separately. My immersion in the literature extended for about a year at the start of the research. I repeated the search annually throughout the research aiming to identify new literature for inclusion as it was published. An early iteration of this literature review has been published in a peer-reviewed journal (Williams, 2010) (Appendix 9d).

## **Searching the literature**

In order to undertake this narrative review I searched the Medline, CINAHL, BNI, Ovid, Emerald Management, Education-Sage Full Text and ERIC databases, using MESH and free text variations on the key words ‘nursing’, ‘work-based learning’, and ‘facilitation’. The terms were truncated as appropriate for each database and combined using Boolean terms AND and OR. I set a date limit of papers published from 2000 onwards.

In addition to these searches further literature was identified using a snowball technique directly from the obtained papers. Some of this further literature was outside some of the previously set guidelines in that it included seminal literature published pre-2000 and literature that although directly relevant to healthcare in general, was not specifically referring to nursing. Whilst locating the full text articles for the review,

some additional reports, guidelines, theoretical papers and conference proceedings were serendipitously located. My overall aim in these searches was to systematically locate and read as much of the available literature as I could in order to develop an understanding of the topic area. I was not attempting to undertake a systematic review of the literature, so whilst I have identified and read a large amount, I make no claims to have read it all.

## **Results of the search strategy and emergent themes**

A quick scan revealed that the majority of the published literature around work-based learning came from within higher education rather than practice. Whilst some of the literature is empirical, a large amount of the literature particularly the earlier literature, is the authors sharing examples of WBL, or evaluating WBL courses they had set up. The reasons for this could be due to staff in Higher Education Institutions being required to publish whilst those in practice are not. In addition, back in 2010 the idea of the academic WBL course was still relatively new and not particularly widespread outside of the main recognised ‘work-based learning’ centres. To gain an understanding of the development of WBL and provide the background, I also located and read some of the key reports eg. the Dearing report (1997), and the Leitch report (2006). Amongst the literature I identified that there are quite a few papers that state they are phase one of a project, however by the end of the paper the authors either state that phase two of the project never happened, or I was unable to find a publication around phase two. This could be due to a variety of reasons from lack of organisational sponsorship for the continuation of the project, to changes in publishing. In addition to the literature from peer reviewed journals I undertook a further tranche of reading for background information that included discussion articles, editorials, reports, and textbooks.

The literature around facilitation was more of a known entity for me as I had completed a PG Certificate in Facilitation and life-long learning in preparation for starting this research. It was this knowledge that led me to the conclusion that simply searching for the literature using the one search strategy would narrow my field too much. In the event the facilitation literature relating to nursing and non-academic work-based

learning was quite limited, so I expanded my search to include research papers that were focussed on the facilitation of learning in general. I also included some practice development literature where it had an explicit focus on the facilitation. I excluded more recent papers that were specifically about knowledge translation (implementation science), because as I explain, they appear to be more about change management than facilitating learning (Kitson, Harvey, 2016).

The main themes that emerged from the literature were:-

- Work-based learning
  - Definition
  - The link between learning and practice
  - WBL academic courses
- Learning as a registered nurse
  - Learning as external work
  - Learning as a way of being
- Contextual issues for work-based learners
  - Organisational culture
  - The involvement of managers
  - Time
  - The ability of staff to participate
- The facilitation of learning
- Facilitation as a process
- The role of the facilitator
- The facilitator as a person
- Frameworks for facilitation

This narrative review will therefore use these headings as a guide.

## **Work-based Learning**

### **Definitions**

The majority of adults' experience work and learning as inevitably intertwined. As adults the majority of us have to work. As thinking beings, we are constantly learning. Work-based learning is therefore based on the philosophical assumption that adults are self-directed, autonomous and self-motivated (Sobiechowska, Maisch, 2007), and it attempts to create learning opportunities that take advantage of that. There are many

different definitions of work-based learning but some of the key features are that the learning arises from the work itself (Clarke, Copeland, 2003, Raelin, 2008) and is student-centred (Flanagan, Baldwin & Clarke, 2000, Dewar, Walker, 1999). It uses experiential learning (Little, Brennan, 1996, Dewar, Walker, 1999) and critical reflection (Rhodes, Shiel, 2007) in the creation of new professional knowledge (Gallagher, Holland, 2004). The learning should also be designed to meet the needs of the work-place (Clarke, Copeland, 2003, Sobiechowska, Maisch, 2006, Swallow et al., 2001). After 2010 new features begin to appear in definitions. These include WBL occurring in the work environment in interaction and cooperation between staff (Bjork, Toien & Sorensen, 2013, Nisbet, Lincoln & Dunn, 2013, Govranos, Newton, 2014) and are most likely to be due to the increase in what is referred to as ‘informal’ work-based learning rather than academic WBL. Work-based learning as per the definitions above challenge the learning status quo in three fundamental ways: firstly the learner has control over the learning process; secondly it values experiential learning; and thirdly the focus is the learning and the development of the individual’s ability to learn through their experiences (Walker, Dewar, 2000). In addition to this Raelin (2008) adds that learners should become so comfortable with learning they are able to question the underlying assumptions of practice.

## **The link between learning and practice**

The NHS Employers website (NHS Confederation, 2019) suggests that organisations should have a ‘culture’ of work-based learning in place, which is a step forward from the statement in 2004 that organisations need to simply ‘value’ workplace learning (Department of Health (England), 2004). In many organisations however work-based learning is still perceived as being little more than receiving on the job training to perform tasks, with many areas having the mistaken assumption that being a learning organisation is about articulating a clear vision and providing lots of training (Garcarz, Chambers, 2003, Garvin, Edmondson & Gino, 2008). This is also evident from various government publications (The Welsh NHS Confederation, 2017, The Welsh NHS Confederation, 2015) where the focus is on training and skills development rather than professional learning per se, and this is despite evidence that suggests that an organisation cannot develop a learning culture simply by providing education and

training (Schoonbeek, Henderson, 2011). In an evaluation of the role of clinical education facilitators (CEF) McCormack and Slater (2006) found that whilst they did what they were supposed to do, which was to co-ordinate the education and training needs of Registered Nurses, there was no clear evidence that this contributed to the development of a learning culture. A similar criticism has been made by Webster-Wright (2009) who looked at the concept of Continuing Professional Development and found that it often ends up as “episodic updates of information delivered in a didactic manner, separated from engagement with authentic work experiences’ (p703). In a systematic review of qualitative studies about work-based learning Nevalainen et al (2018) concur with this. They conclude that learning and work are often seen as separate, however when the workplace is seen as a learning environment then learning is understood as occurring alongside the work (Nevalainen, Lunkka & Suhonen, 2018).

As stated previously, until recently there was very little evidence in the published literature of classroom-based learning making a direct difference to the development of practice (McCormack et al., 2006). This idea is not new; the National Committee of Inquiry into Higher Education (Dearing, 1997) questioned the ability of classroom-based educational approaches to achieve real and sustained changes in practice back in 1997. The recommendations from that report were that education needed to be more responsive to the skills and knowledge required by the workforce (Dearing, 1997). The suggestion from this is that it is the type of education that is the reason for the failure. A systematic review of the literature published between 1990 and 2007 evaluating the impact of post-registration nursing and midwifery education on practice found that the learners benefitted in relation to knowledge and skill acquisition, and a change in attitudes and perception (Gijbels et al., 2010), but once again the benefits identified mainly relate to the personal and professional development of the learners involved rather than improvements to practice or benefits to patients. These findings however may be due to the complexity of trying to attribute causality, rather than practice or patient outcomes not happening (Clark, Draper & Rogers, 2015). The biggest study that suggests that the education of nurses does have an impact on patient care is the research carried out by Aiken et al (2014). The RN4CAST study was designed to provide evidence to inform decisions about workforce planning and workforce investments around nursing. The researchers reviewed 488 hospitals in 12 European

countries and noted that there were considerable difference in the nurses' workloads and educational levels. The key finding that is relevant to this review is that for every 10% increase in the proportion of nurses with a bachelor's degree there was an associated 7% decrease in mortality for patients. As the study is an observational cross-sectional study it again cannot show causality, and the authors note a number of other limitations that could have affected the results. Nonetheless the study lends weight to the argument that developing nurses personally and professionally, however it is done, does have an impact on patient care.

## **WBL Academic Courses**

At the start of this work (2010) most of the published literature around work-based learning was about academic courses that were accredited by a Higher Education Institute (HEI) or HEI courses that contain a 'workplace learning' element. Amongst this literature there does appear to be two clear types of course. Firstly, there are the work-based learning courses that are designed to give practitioners the knowledge and skills to do their jobs, or to take on new roles (Chalmers, Swallow & Miller, 2001) and secondly there are courses that are designed to focus on the learning process and lead to changes in practice (Chapman, Howkins, 2003). These different courses are described as being at two ends of a continuum rather than mutually exclusive (Brown, Harte & Warnes, 2007). A useful way of describing the different types of work-based learning is that put forward by Chalmers et al. (2001) as part of an operational definition of accredited WBL, with the learning being FOR work, AT work, or THROUGH work. The first type of course involves the development of a set of skills and underpinning knowledge to meet employer's requirements. They aim to develop staff who are capable of completing a range of carefully chosen tasks to a known level of effectiveness and efficiency. It also ensures that junior members of the workforce are encouraged to up-skill and meet employer needs for a stable effective workforce. These courses are referred to in one HEI as affirmative work-based learning (Brown, Harte & Warnes 2007). This end of the continuum also contains those clinical skills courses that are designed to build 'knowledge, skills and competence within the specialist area' (MacLeod, Lyon, 2007). At the other end of the scale are courses that have been referred to as transformative work-based learning (Brown, Harte & Warnes

2007). They are described as liberating creativity and enterprise, where the end results evolve as the learner engages with the work-setting. The underlying ethos is to disturb the status quo and create change in the workplace, and they enable 'more senior' members of the workforce to apply new learning to take them to a higher level of decision-making and leadership (Brown, Harte & Warnes 2007). MacLeod and Lyon (2007) also describe courses at this end of the continuum as 'developing individual learning outcomes for more senior staff', informed by personal development plans in collaboration with practice-based educators. In their evaluation they state that those learners who had these individual contracts felt that they had ownership of their learning, and also that the work generated by these contracts was useful to the areas concerned and had the potential to enhance practice and patient care (MacLeod, Lyon, 2007).

These two papers both describe the second type of work-based learning as being designed for 'more senior staff', and this raises the question about the learning for more junior staff. With an all graduate entry to the profession, developing nurses who have been taught the skills associated with graduateness (clinical judgement, critical thinking skills, communication skills, assessment skills and the ability to identify their own professional development needs by engaging in reflection in and on practice), why then are only the senior staff enabled to work with learning contracts that are at the transformative end of learning according to the definition by Brown et al (2007)? It could be suggested that in order to change practice, the nurses that are closest to the actual care delivery should also be enabled to create knowledge and lead change in the workplace using transformational work-based learning methods. However, this would require consideration of a model of work-based learning that 'fits' all grades of staff, and also a change in culture to enable more junior staff to make changes to practice.

Rhodes & Shiel (2007) describe a possible approach to this. They start with the focus on the learner, where the learner is provided with the opportunity to "interpret, analyse and challenge current thinking and practice, in order to develop new personal knowledge, understanding and attitudes and thereby improve their own professional practice" (p175). Key to the success is the ability of the learners to develop as highly motivated active learners able to work autonomously. They base their course around the idea of individually negotiated work-based projects that are designed to benefit

both the learner and their employing organisation. These projects are referred to as real change projects that are designed to take into account the intention of the learning, and the individual's role and position in the organisation (Rhodes, Shiel, 2007). There is no mention in this of these change projects only being available to 'senior' staff, instead there is the recognition that the project needs to be chosen to reflect where the person is in the organisation – working with, rather than against, the constraints. The outcomes of the projects were empowering learners, a customised learning experience, and developing practice in the organisations (Rhodes, Shiel, 2007).

There would seem to be a big difference between critically analysing current work and working practices and then learning and developing oneself and one's practice as a result of that, and simply learning the work that is undertaken in the workplace. However, it has to be recognised that it is unusual for education of any sort to sit firmly in only one box, and a degree of overlap has to be expected. The majority of this literature also views work-based learning as something that stands as a discrete event, occurring for the duration of a course. This is exemplified by Chapman and Howkins (2003) who describe a course which was meant to encourage the students to identify aspects of their practice that could be changed and then guide them to do it. They go on to say however, that although the nurses gained knowledge and enthusiasm to develop practice, they didn't have the time to do it until the course was increased from 12 to 15 weeks (Chapman, Howkins, 2003), which in itself raises questions about the sustainability of any change that occurred in 3 weeks. It has to be questioned therefore whether work-based learning that is closely tied into an HEI 'course' is an effective way of ensuring continuing development of practice, or does it just shift the focus once more on obtaining the award or 'piece of paper', with learning that stops when the course ends. It would seem to be preferable that learning is seen as something that is embedded through the culture of the workplace, and is based on "collegiality, respect, collaboration and camaraderie" (Tanaka et al., 2019 p647).



## **Learning as a Registered Nurse**

Life-long learning in nursing has been defined as

“a dynamic process, which encompasses both personal and professional life. This learning process is also both formal and informal. Lifelong learning involves seeking and appreciating new worlds or ideas in order to gain a new perspective as well as questioning one's environment, knowledge, skills and interactions” (Davis, Taylor & Reyes, 2014 p444).

People who are life-long learners are believed to be more committed, take more initiative, have a broader and deeper sense of responsibility in their work, and learn faster (O'Brien 2006). O'Brien believes that it is the personal fulfilment that life-long learning generates in the individual workers that is most important (O'Brien, 2006), although it could also be seen as advantageous to the organisation.

### **Learning as external work**

For managers considering the use of work-based learning to assist in the delivery of high quality care, the descriptions of work-based learning courses that build the knowledge, skills and competence of the work force may appear to fulfil many continuing professional development needs for Registered Nurses and are relatively 'safe' and quantifiable. However, adopting a work-based learning approach as suggested above by the 'transformative' model (Brown, Harte & Warnes 2007), will require nurses to start actively participating in, taking responsibility for and generating their own learning from everyday practice. This change of mindset may initially be difficult, as nurses are generally more familiar with being passive recipients of teaching and may find the freedom of this approach difficult to manage (Wilson, McCormack & Ives, 2006). Indeed it has been found that learners who are unfamiliar with work-based learning find the actual process of undertaking academic courses in this way to be difficult, particularly when they are not given enough help and direction at the outset (Sobiechowska, Maisch, 2007, Kirwan, Adams, 2009). Many try to make the work-based learning model 'fit' into the more traditional academic model that they are familiar with (Rhodes, Shiel, 2007, Chapman, 2006). It could be argued however

that this approach is more in keeping with the skills that ought to be expected of both professionals and graduates. Change is never easy however, and other reasons that are put forward by nurses as to why they were unable to use their knowledge to change practice include pressure of work, the workplace being 'non-dynamic' and apathy from colleagues (Hardwick, Jordan, 2002).

Professional development is considered by many people to be synonymous with external learning where outcomes are measurable, and the learning is 'captured' on paper so it can be shown to someone else to prove it happened (Webster-Wright, 2009). Being awarded a certificate or getting something that 'proves' that the learning was achieved legitimises this way of working (Bourner, 2003), and can be used as criteria for job applications, promotions etc. Although some external learning is planned as part of career development, a lot is rather more ad hoc (Clark, Draper & Rogers, 2015), and undertaking 'external' learning is often seen as being a 'personal' thing, with the nurse expected to undertake a lot of the work in her own time, as well as pay for it (Tame, 2011). Although some employers require the nurse to provide evidence of the impact of the investment of money and time from work, not all employers do (Clark, Draper & Rogers, 2015). In fact, for many nurses the experience is one of being unable to use their learning to improve practice (Augustsson, Tornquist & Hasson, 2013, Rijdt et al., 2013). The dissociation between learning and work has also contributed to some nurses feeling resented by their colleagues when they are away 'learning' and therefore not available to contribute to the everyday work in practice (Ramage, 2014). It is not surprising therefore that for the majority of nurses learning is seen as being additional work, slightly removed from the everyday world of their practice (Govranos, Newton, 2014) and requires motivation and organisation to achieve, as well as inevitably encroaching into home life (Clark, Draper & Rogers, 2015). This means that to be successful home life must be able to accommodate this intrusion, and the inability of home life to do this will often be the deciding factor for a nurse wanting to undertake further professional development (Murphy, Cross & McGuire, 2006).

## **Learning as a way of being**

A registered nurse is a professional job, however ‘being professional’ in that job is about a way of being. The issues that confront practitioners in their everyday clinical practice are to do with complex, frequently changing, unpredictable situations, interpersonal relationships, and the underlying culture. It is these issues that Vaill (1996) describes as ‘permanent white water’ and Schön (1983) describes as ‘the swampy lowlands of practice’. These issues are not to do with ‘facts’ but are actually more to do with the culture and the individual values and beliefs of all people involved in the interaction. Basic assumptions (or values) are believed to be extremely difficult to change simply because they tend to be those things that are considered as “non-confrontable and non-debatable” (Schein, 2004 p31). Learning something new in this area therefore requires the learner to re-examine and change some of their most established ideas. This is difficult because by its very nature it is destabilising and therefore causes increased anxiety, something that most people will tend to avoid (Schein, 2004). In order to learn from experience therefore, learners need help to challenge the assumptions underpinning their everyday practice, and then support to enable them to work through the resulting discomfort and anxiety and into learning (Wilson, McCormack & Ives 2006). Without support to question practice there is a danger that nothing will change as learners are not exposed to new ideas and find difficulty diverting from established practices (Siebert, Mills & Tuff, 2009). When considered in this way it is easy to see that a simple transmission of facts, while sometimes necessary, will not generally support or enable nurses to become life-long learners in their everyday worlds.

Webster-Wright (2009) believes that as professional knowing is “embodied, contextual and embedded in practice” (p724), then professional learning should also occur through practice experience and reflective action in context. An example of this is given in a paper by Duff et al (2014), where they assessed the impact of a work-based learning programme that consisted of a supportive clinical learning network, opportunities for practice, and reflective discussion and feedback in the workplace guided by coaches and educators. This was delivered via clinical simulation scenarios, self-directed and on-line learning, and “coaching support in the clinical area for three months post programme” (Duff et al 2014 p105). The most effective intervention was

felt to be the support and feedback offered in the clinical area, and the authors postulate that this may have been because the issue was not so much a lack of knowledge, but rather a lack of confidence to apply the skill. Thus, it is through active engagement with experience and critical reflection, rather than simply learning skills and developing competence, that learning (and change) occurs.

It could be suggested that unless nurses are assisted to learn how to learn from their practice, and the culture is changed to be supportive of this form of learning, the didactic form of education - described as 'banking' education by (Freire, 1996) - even if it is delivered in the workplace, is in danger of just increasing dependence giving rise to a greater and greater need for training just to maintain the status quo. This could be seen as an example of what Senge et al. (2005) refer to as "shifting the burden" (p204), where people act to ameliorate the symptoms of a problem (in this case the failure to improve practice) and end up becoming more and more dependent on the symptomatic solution (training), without considering and dealing with the cause of the problem in the first place (the lack of a culture supportive of learning from practice). Freire (1996) suggests that whilst education can help people to understand their world, changing the education techniques will not change society. To achieve that he believes that education and learning needs to be deeply connected to the everyday realities in which people live and work, something that Nevalainen et al (2018) also agree with. Freire's suggestion was to involve critical dialogue and a joint creation of knowledge between adults who are involved in a communicative relationship and are treated as equals. This would have the aim of increasing their feelings of self-worth and self-confidence, and lead to increased motivation and ability to change and improve the reality of their own lives (Aloni, 2007), rather than being fed information by dominant groups, which can end up as manipulative social control (Freire, 1974). As suggested by Garvin et al (2008), people need to be able to "create, acquire, utilise and transfer knowledge" and this cannot be achieved by training alone.

# **The Impact of Contextual Issues on Learning**

## **The Organisational Culture**

In a concept analysis of the term work-based learning, Manley et al (2009) identify an organisation-wide learning philosophy and a supportive organisation-wide infrastructure as the two enabling factors for the successful implementation of work-based learning. The supportive workplace was also found to promote self-directed learning amongst nurses (Chakkaravarthy et al., 2018). Organisations with strong learning cultures are characterised by non-hierarchical, team-based learning structures that prioritise learning, empower change, involve staff and are open to suggestion and innovation (McLaren et al., 2008). Aysola et al (2018) add to this the need to feel recognised and valued in the work and learning environment, and it is not hard to see how developing learning cultures has the potential to increase the motivation and commitment of nurses. Aiken & Patrician (2000) highlight the importance of autonomy, control over the practice setting, the nurse-doctor relationship and organizational support in the development of a culture that supports professional nursing practice, which in turn is felt to be essential in the development of a learning culture. The link between staff development and motivation has also been shown to make hospitals more attractive places to work (Kramer, Schmalenberg, 2004, Stordeur, D'Hoore & The Next Study Group., 2007, Tanaka et al., 2019) and there are other studies that demonstrate a positive relationship between critical thinking, autonomy, professional status, staff development, and job satisfaction (Curtis, 2007, Zurmehly, 2008, Arian, Soleimani & Oghazianc, 2018). Practitioners in these situations could be seen as 'thriving at work', which is defined as a 'psychological state in which individuals experience both a state of vitality and a sense of learning at work' (Spreitzer et al., 2005 p538).

Whilst working in an organisation with an effective learning culture is ideal, this is not always possible. However, the underlying culture of an organisation can impact negatively on the effectiveness of learning. Ellinger & Cseh (2007) found that an organisation with a silo mentality, lack of time through workloads, a negative mentality and a fast pace of change, inhibited learning. Contextual factors in the

learning environment can also disrupt attempts to facilitate change, even if the change is to try to help develop a learning culture eg. Bunniss, Gray & Kelly (2012) describe how an external facilitator was brought in to facilitate a programme to develop a GP practice into a learning practice. The facilitator was attributed as being key to the success of the programme, helping to break down traditional hierarchies and encouraging the involvement of all staff groups. It proved difficult for the facilitator to engage the nurses however, and it transpired that some of the nurses felt that there were things going on under the surface related to historical relationships and experiences, that had not really been dealt with (Bunniss, Gray & Kelly, 2012). This raises the question of whether an internal or an external facilitator would be more appropriate in a situation like this. An internal facilitator could have been aware of the historical issues and been able to react appropriately, however the external facilitator came with no invested interest and might be seen as more neutral, and therefore able to work with everyone.

Girod and Rickaby (2008) found that organisational support was the key difference between those students who did well in their learning as opposed to those who had difficulty. What is known however is that when budgets are tight it is the continuing professional development of staff that tends to be hit first. At the start of this research the Department of Health stated that high quality care for patients was an aspiration that was only possible with high quality education and training for all staff involved in NHS services (Department of Health (England), 2008). Since then however there has been a continued lack of investment in continuing professional development (CPD) for NHS staff in England, and it is now set at £2bn lower than it would have been if spending had continued at 2006/7 rates (Buchan et al., 2019). A sum of £84m is currently dedicated to workforce development in the English NHS, however this has been described as “wholly inadequate to equip this huge workforce with the skills and capabilities it needs to be as productive as possible” (Health Foundation, 2018 p10). Comparable budget figures are not available for Wales, however it is known that in 2012 the NHS in Wales spent proportionately less of their training budget on nurses and allied health professionals (35% of the budget on staffing groups who make up 40% of the workforce) (The Welsh NHS Confederation, 2015). This lack of resources

will inevitably impact on staff attempting to engage with learning in the workplace, both from a practical point of view as well as the feeling of being valued.

## **The Involvement of Managers**

Work-based learning requires the manager to be actively involved working with the individual practitioners to help them select appropriate topics and projects to engage with. Managers also need to support staff through the resulting process of learning to reflect and analyse situations, develop their reasoning skills and work with patients (Moore, 2007). Difficulties will arise when managers and colleagues are not perceived as supportive (Govranos, Newton, 2014) The role the nurse manager chooses to take on their ward with regards to learning sends a signal to all staff and directly influences the learning culture (Bjork, Toien & Sorensen, 2013, Augustsson, Tornquist & Hasson, 2013). In exploring the relationship between thriving in work and a leader's empathy however, Mortier et al (2016) found that whilst there was a positive relationship between authentic leadership and learning it was not brought about by the empathy of the leader. One of the reasons they suggest for this is that nurses may be more inclined to seek support from their peers than their leaders, and thus it could be the social support of colleagues that have more of an impact on nurses learning than the manager's empathy. However, colleagues are not always supportive, and there are many examples of the learner being inhibited by their colleagues (Ramage, 2014). The manager has been found to have a great impact on a learner's ability to implement change as a result of their learning. The manager does not have to be deliberately obstructive to block progress, as being either disinterested or unresponsive is enough (Currie, Tolson & Booth, 2007). Managers who role model learning and development, and encourage, support and reinforce the importance of developing others were considered by the workforce as positive factors (Boamah et al., 2018). Managers who do not support staff to facilitate others learning, or who won't let their staff learn and develop were not surprisingly, felt to inhibit learning (Ellinger, Cseh, 2007).

Mulcahy et al (2018) identified that facilitating practice development is easier when the ward manager is part of the facilitation team, and managers engaging with their staff in work-based learning may therefore find that their role changes from being the

planner and driver of change to becoming the facilitator who supports their staff to take on that role. To enable this, the manager will need to ensure that staff have the authority to carry out any required changes (Williamson, 2005), thus reducing any structural conflict (Fritz, 1984) or local politics (Williamson, 2005) that may currently be inhibiting them. This has multiple benefits, firstly giving the staff ownership of the change, secondly helping to develop practice for the benefit of the patient, and thirdly enabling staff to learn in and from the process.

## **The Allocation of Time**

The inability of managers to release staff from practice seems to be the impetus behind many HEI work-based learning courses, with work-based learning appearing as an attractive cost-effective option for managers who are faced with having to release staff for 1 day a week to undertake traditional education. The issue of time to undertake work-based learning is a key consideration (Govranos, Newton, 2014), but in many cases previously understood study leave requirements for classroom-based learning methods have simply been transferred to the new work-based learning model. This is exemplified by Jonas & Burns (2010) who report that because their course required only two formal days in college, some managers perceived this as the only study leave that the course participants needed. An alternative scenario is reported by Swallow et al (2000) who found that because it was work-based learning and the ‘seminars, lectures and tutorials’ were therefore delivered on Trust premises, the participants were simply ‘taken off the shop floor’ to attend, leaving the nurses left behind short and unable to deliver adequate care to patients. Ramage (2014) identifies that the lack of time, as well as thinking of colleagues are both factors that significantly impact on the work-based learner

“To deflect the criticism and censure of their colleagues for taking time out from practice, many of the learners used their days off to set up legitimate uninterrupted space to spend time with their mentor for supervision and assessment at work and meet up with their educational advisor and attend action learning sets” (Ramage, 2014 p499)

This could be addressed by a greater understanding of the process of WBL, and recognition of the time that is required to achieve it successfully, without it having to



impact on home life (Govranos, Newton, 2014). Generally academic work-based learning requires a greater amount of time and effort for learners than more traditional classroom-based learning methods (Kirwan, Adams, 2009), so expecting nurses to undertake this with less, or in some cases no study time, is unrealistic when staff are already working at a high level of intensity. Although this would suggest that work-based learning is not the potentially 'cheap' option that it appears to be, it may be an example of a 'spend to save' philosophy. This is where nurses add value to study time because they are contributing to improved patient care and providing evidence of practice development, while they are learning in practice (Chapman, Howkins, 2003). Work-based learning could therefore be seen as more valuable than learning that takes the learner away from the workplace (Fulbrook, Cockerell, 2005).

### **The Ability of Staff to Participate**

A key component of a learning organisation is that staff participate at all levels, and there is huge potential for work-based learning to develop as a collective activity, eg. colleagues can assist with each other's learning by participating in supported reflective practice together such as action learning sets. However, feeling that your colleagues do not support your learning can result in staff questioning the value of their own learning (Ramage, 2014). When considering culture, McCormack & Slater (2006) found that staff at a higher grade were more satisfied with the culture in their workplace than those who were more junior. This may be a contributory factor in failing to develop a culture that is conducive to learning for all, because if the more senior staff feel that the culture is supportive of professional practice then they are less likely to question it, and therefore less likely to alter it for the benefit of the more junior staff. This was highlighted in a study by Currie et al (2007), who looked at the experiences of the graduate specialist practitioner and how they engaged in the process of practice development. They found that structural power was very much in evidence in the workplace, and the position of the nurse in the hierarchy strongly affected their ability to engage in the development of practice. Those nurses who were not in a position of authority in the nursing team faced significant barriers to innovation, something that was foreign to those who started in a G grade (ward sister) position. In order to enable staff to change practice therefore, they first have to be empowered and feel valued, a

fact recognised by Aysola et al (2018). It could be suggested that this is an area of challenge for managers, to first critically analyse their workplace to determine if the prevailing culture is enabling for all staff, and then to do something to change it, if it is found to favour only the most senior.

Work-based learning that is seen as purely training fits well into a hierarchical organisational model as it is relatively quick, easily measurable, and reinforces the status quo. Alternatively work-based learning that encourages staff to question the underlying assumptions of both their own practice and the current practice in the workplace makes the whole process less controllable and is potentially difficult to achieve in a risk-averse organisation. It could be argued however that it is only this form of learning that really has the potential to change practice. Thus to be effective, work-based learning needs to support the learners to both identify and then question the everyday assumptions that are currently in force in their practice or workplace, and then further support for them as they work through the resulting discomfort to change. This highlights the importance of a workplace culture that is ready for work-based learning, a manager that is supporting a learning culture and is willing to live with the uncertainty and ‘messiness’ that this creates, and the key role of someone to support the learner as they learn (Williams, 2010).

## **The Facilitation of Learning**

In the concept analysis of work-based learning, Manley et al (2009) identified that one of the necessary attributes was a skilled facilitator. They went on to provide a list of what a skilled facilitator would do. This list includes preparing the learner and the environment for learning; developing a trusting working relationship; negotiating learning contracts and actions needed to achieve the goals; helping people to learn opportunistically and in one-to-one and group learning situation; role modelling and sharing own knowledge; using a wide range of skills; and facilitating organisational, cultural and practice change with individuals, teams and organisations (Manley, Titchen & Hardy, 2009). A review of five concept analyses of facilitation (Cross, 1996, Burrows, 1997, Harvey et al., 2002, Simmons, 2004) and two literature reviews (Dogherty, Harrison & Graham, 2010, Reeves et al., 2016) demonstrate a degree of

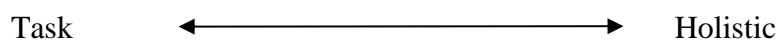
consistency with this. All of the concept analyses identify the importance of relationship building, shared decision making, and effective communication skills. There is also recognition of the need for the facilitator to have appropriate personal qualities for the job. Finally there is a shared understanding that the environment needs to be conducive to facilitation, with the voluntary participation of learners who understand the process. This degree of consistency is despite the concept analyses considering facilitation in regards to learning (Burrows, 1997, Cross, 1996, Reeves et al., 2016), practice development (Simmons, 2004) and implementing evidence-based practice (Harvey et al., 2002, Dogherty, Harrison & Graham, 2010).

There are however, some differences in the concept analyses. Simmons (2004) has included 'leadership of change' in her concept analysis of 'facilitation of practice development'. Similarly (Dogherty, Harrison & Graham, 2010), when considering facilitation designed to achieve evidence-based practice, includes planning for change, leading and managing change, monitoring progress and ongoing implementation, and evaluating change. The taxonomy that they went on to develop has much more of an emphasis on the implementation and management of the change rather than the learning of the individual. It might be suggested therefore that when the facilitator is in a role that requires change to practice there is a need for them to focus their facilitation more as a leader/manager role. However, when Wales et al. (2013) describe a course designed to prepare facilitators for transformational practice development, although change is one of the topics that is included in the course, the subject is in relation to the facilitators working with clinicians to enhance changes in practice, rather than focussing on the change itself. This would suggest that it is not the presence of change that is the defining feature, but rather the intent of the facilitator.

The differences between the definitions, and in particular the much more task-focused elements in the Dogherty et al (2010) paper, highlight that there are different processes that can be used in successful facilitation. The key difference between the definitions is the idea of the facilitator being in an expert role where the change process is finite, or the facilitator being an 'enabler' where the process of change is ongoing (Harvey et al., 2002). Rycroft-Malone et al. (2004) summarise this position by describing two different roles of facilitators, the first being more of a doing role which is likely to be practical and task driven, and the second being more of a holistic enabling role which

is more likely to be developmental in nature, “seeking to explore and release the inherent potential of individuals” (p139). However rather than being an either/or situation, Harvey et al. (2002) views the two roles as being at either end of a facilitation continuum, and Rycroft-Malone et al.(2002) believes that a skilled facilitator should be able to utilise a whole range of different approaches to achieve their goal. The ability to use the full range of the facilitation continuum would lend weight to the description of skilled facilitation by Manley et al (2009).

## **The Facilitation Process**



The process of facilitation considers the interventions that are carried out by a facilitator with the intention of achieving a specific result. This specific result could vary from the achievement of a task to a change in understanding or way of being. Facilitators work in both group and one-to-one situations and there are similarities in the process of facilitation no matter what the purpose. Within the education field, the concept of facilitation has emerged from the fields of counselling and student-centred learning, influenced by humanistic psychology and in particular Rogers’ work on client-centred approaches to counselling (Rogers, 1983). Facilitation in this respect is more than simply an approach to learning, but rather is underpinned by a person-centred way of being that places the emphasis

“on the dignity of the individual, the importance of personal choice, the significance of responsibility, the joy of creativity. It is a philosophy built on a foundation of the democratic way, empowering each individual” (Rogers, 1983 p95)

Rogers believes that the process of facilitation is therefore about enabling individuals to develop the skills to reflect upon and revise their own understandings and behaviours, and the facilitators’ work is based on the principles of trust, understanding and realness (Rogers 1983). Heron (1999) again from the humanistic school, believes that as the learner is a whole person, the whole person needs to be involved in learning.

He includes in this not only theoretical knowledge and comprehension but also emotions and attitudes, interpersonal relations, and social and political processes among others. It is this learning that he terms holistic (Heron, 1999).

The key processes within facilitation therefore appear to be relational, with Needham et al. (2016) believing that interacting and communicating effectively is the essential aspect of facilitation. In an effort to understand the nature of facilitated learning Ruiz et al. (2013) observed a variety of different interprofessional learning workshops and found that there were three forms of interactions. These were described as interactions that were facilitator-controlled and generally involved information giving; interactions that were facilitator-driven, where facilitators and students both actively participated but the facilitator decided on the topics to be discussed; and interactions that were student-driven, where students raised their own issues and interacted amongst themselves. All the facilitators spent the most time in the facilitator-driven mode as they tried to get students to interact using controversial and open-ended questions as prompts. The least amount of time was spent in the student-driven mode. These three types of interaction could be seen as similar to Heron's three modes of group facilitation, which are hierarchical, co-operative and autonomous (Heron, 1999). In the hierarchical mode you are doing it for the learners, in the co-operative mode you are doing it with the learners, and in the autonomous mode you have given it over to the learners. The idea of facilitator-driven interventions was echoed in a study by Rowan et al (2007) with midwifery lecturers. They attempted to balance support with the desire to encourage an active enquiring approach among their students. They did this by questioning to tease out students' knowledge and reasoning, and challenging them to think about what they were saying. There was some uncertainty about the amount of intervention that was appropriate, but all agreed that the amount of support, guidance, nurturing and reassurance that the student needed reduced as they progressed, which may suggest that over time the students would evolve to become a student-driven group. The idea of asking 'conversation-provoking' questions was also apparent in an evaluation of a national practice improvement and work-based learning programme in Australia (Essentials of Care) (Mulcahy et al., 2018) To work in this way required patience and was time-consuming as it was much easier and quicker to offer solutions rather than let the team work out their own solutions. It required the

facilitator to be solution focussed and positive, to believe in themselves, their team and the process, and to be self-aware with the ability to guide rather than tell.

“The facilitator enables staff to reflect and engage in critical dialogue about their workplace beliefs, values and work practices to create an environment where staff can reflect and challenge rituals and assumptions, leading to action planning to improve workplace cultures and care quality” (Mulcahy et al., 2018 p4)

The idea of interaction and communication being the key processes in facilitation is supported by Sargeant et al (2010). They developed a rating scale to test the skills of facilitators of interprofessional education (IPE). The authors suggest that the 15 items on the scale could be used as a concise summary of the skills required for IPE facilitation and its use by facilitators would inform their self-development. Twelve of the fifteen skills involve personal interaction and communication and are around asking the right questions, encouraging interaction, respecting everyone, encouraging active listening, and encouraging the free exchange of ideas. This process of facilitation seems to be very similar no matter what is being facilitated. Haith-Cooper (2003) explored the experiences of problem-based learning (PBL) facilitators, and again found that questions that were thought provoking, that provoked decision-making, and that broadened out the discussion were felt to be appropriate interventions. Observation and feedback was useful for process and group dynamics, and for reminding and reflecting to steer students back on course, and there was a need to be flexible and not force the process. Similarly Ellinger & Cseh (2007) in a non-healthcare context found that the employees who were facilitating colleagues' learning in work were providing feedback, role-play, observing, listening and asking questions, in addition to the more task focussed processes of explaining, walking through things step by step, sharing materials and resources, using examples, and removing obstacles. Manley & Titchen (2016) worked with aspiring nurse consultants to develop the four pillars of their practice. They used holistic enabling facilitation approaches with the nurse consultants enabling them to collaboratively engage with the programme as co-researchers. The nurse consultants participated in structured reflection in and on practice through action learning sets, and also learned how to facilitate others through the role modelling they observed. The authors claim that they used the 10 principles

for facilitating work-based learning (Manley, Titchen & Hardy, 2009) in order to develop facilitation skills in the participants, learning in and from practice, inquiry into one's own practice, a learning and inquiry culture, and the participants own praxis skills. Praxis is believed to be the heart of effective facilitation, as learners and facilitators are involved in a "continual process of activity, reflection upon activity, collaborative analysis of activity, new activity, further reflection and collaborative analysis and so on." (Brookfield, 1986 p10)

In contrast to a lot of the previous articles Titchen & Binnie (1995) is one of the few that actually gives clear examples of how to facilitate experiential learning within the clinical environment. This way of working uses Dewey's model (1938) where experience + reflection = learning. Although the article refers to this process as 'clinical supervision', it is not the form of clinical supervision as it is generally known and understood in the UK nursing literature. The Titchen & Binnie (1995) article describes three different ways in which an experienced nurse can facilitate the learning in practice of a less experienced nurse. These are helping the nurse to articulate her own intentions, reasoning and actions; the expert nurse making her own practical knowledge accessible to the less experienced nurse; and helping a nurse to learn from a shared experience rather than just observing it. Although the nurses were using these strategies in the clinical environment, the expert nurse was still following a similar process of facilitation - asking questions, sharing their expert knowledge, encouraging reflection and giving feedback – as the facilitators in the classroom. Staff nurses reported that this was a very powerful way of helping them to learn, and was much better than the previous ways of clinical teaching which were more of a 'try this' strategy, and which didn't give the nurses space to reflect, to use their knowledge or to think a problem through (Titchen, Binnie, 1995).

Whilst asking questions was believed to be thought provoking and broadened out discussion, a lot of learning facilitators expressed difficulties with knowing when and how to intervene, particularly in limiting the use of content expertise (Slattery, Douglas, 2014). Anderson et al (2009) addressed these concerns and suggest that the role of the facilitator should be focussed less on the teacher's status as expert and more on their "ability to enable students to ask the right questions within a group context" (p82). Papinczak et al.(2009) approached this from a different angle and explored

medical students views of their lecturers' effectiveness in facilitating problem-based learning. The students felt that the best tutors were those who were able to find the right balance between providing information to keep the group focussed and yet still allowing the session to evolve. Some facilitators managed this well, but others were felt to intervene too often, and some appeared to be unable to find a consistent facilitative style and kept reverting back to a didactic mode of teaching. Whilst some students appeared to prefer lecturers who were more directive, the majority were critical of those who were more controlling (Papinczak, Tunny & Young, 2009).

The ability to change the facilitation style depending on the group's experience was identified as important by facilitators, although some believed that it was changing style with different groups per se rather than changing style as the group matured. In all the studies mentioned, the facilitators did not stick to one particular style but alternated depending on the learning needs of the group. They also had to work with group dynamics in order to facilitate an environment that was conducive to learning for all (Rowan et al 2007). In the Papinczak et al.(2009) study the students felt that lecturers who either didn't recognise the need to adapt, or simply maintained their most comfortable style throughout, were less effective as facilitators. This corresponds to the concept analysis by Harvey et al.(2002) who suggests that expert facilitators can change their style to adapt to the situation. No matter what style of facilitation was being used, everyone wanted an atmosphere of respect and responsibility within their groups and although most lecturers facilitated this, some either expected the group to sort it out amongst themselves, or didn't realise that the process needed active management (Papinczak, Tunny & Young, 2009).

The people who benefitted most from the facilitated way of learning tended to already be motivated, articulate and with a sense of responsibility. It required a degree of confidence and extroversion in the student, and was less effective for weaker, less motivated students (Rowan et al 2007). It was also felt to be more difficult if there were particular home life demands on the student or they were from a culture that was used to viewing the teacher as in charge (Rowan et al 2007). This is not so surprising because whilst facilitation is often seen as making things 'easier', facilitation may actually result in 'difficult' work for students as they are challenged to critically examine their assumptions and ways of acting (Brookfield, 1986, Dewar, Walker,

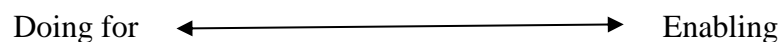


1999), and if they are not feeling ‘safe’ this may impact on their ability to engage (see below).

### **Summary**

Effective facilitation encourages the people involved to discuss, argue, ask questions, construct knowledge relevant to their experience and challenge and develop practice, and is seen as a positive learning experience (Cowman, Hynes & Flint, 2000, Rowan et al., 2007). Effective facilitators are able to adapt their style to meet the needs of the group or person they are working with, and to have the right balance between providing knowledge and answers and allowing the person or group to come to their own solutions.

## **The Role of the Facilitator**



The role of the facilitator considers the activities that someone in a facilitator role is expected to undertake. The continuum in this respect would vary from a facilitator who does things for people to one who enables people to achieve it for themselves.

Jokelainen et al.(2013) undertook a research project looking at the role of a mentor when facilitating a student’s learning. They have developed a model that captures the various ideas that were derived from the focus group discussions. The aspect of the framework that makes it different from most others is that each element has two sides – a pedagogical approach that covers the ‘goal-based guided co-working and evaluating achievements of learning outcomes’, and a human approach that covers the ‘positive encouraging partnership and developing professional competency’ (p63).

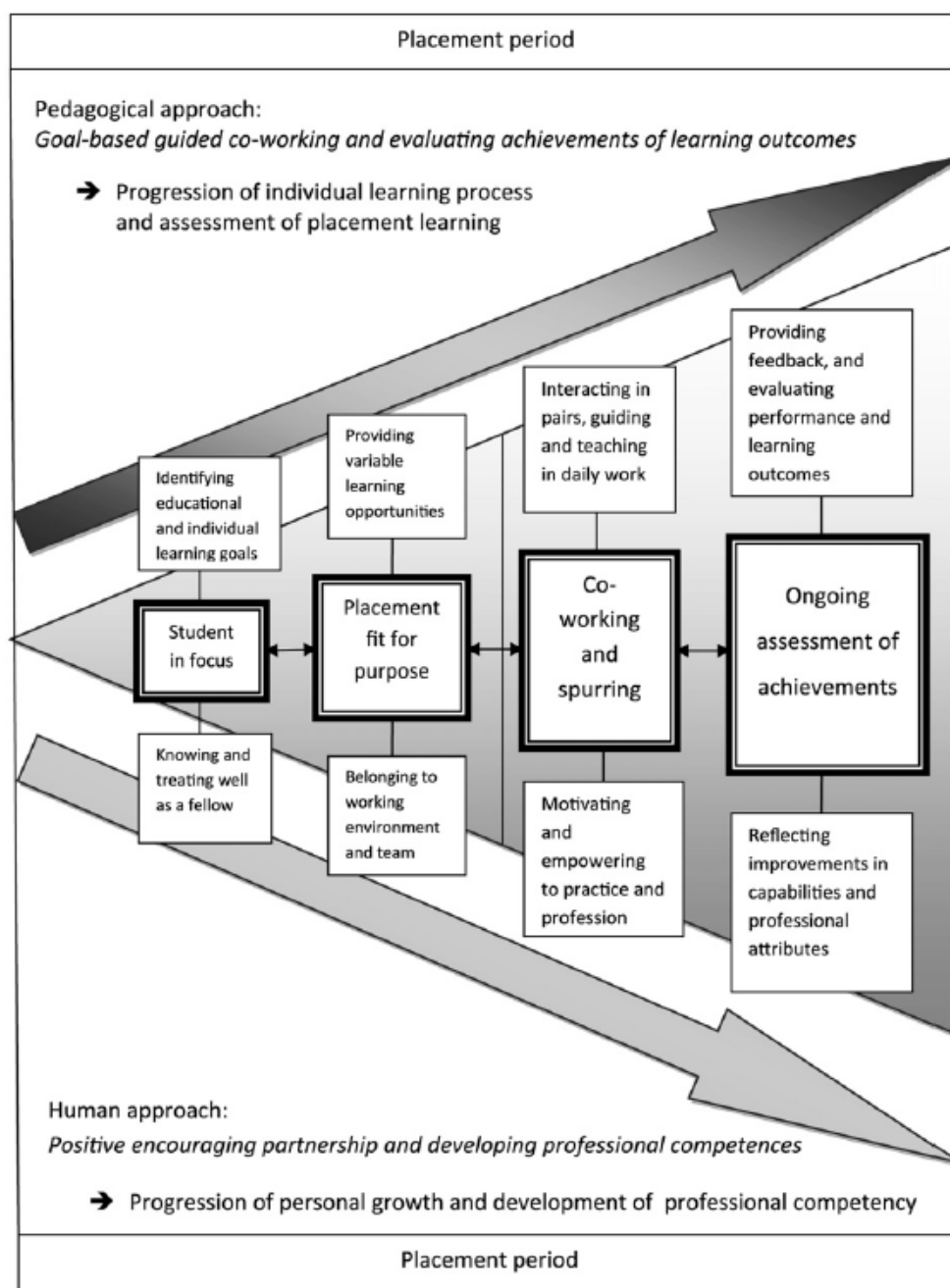


Figure 1. Facilitating learning and professional development of pre-registration nursing students in placement settings. (Jokelainen et al 2013 p63)<sup>1</sup>

<sup>1</sup> Reprinted from Nurse Education in Practice; Vol 13 /Edition 1; Jokelainen, M., Jamookeah, D., Tossavainen, K. & Turunen, H.; Finnish and British mentors' conceptions of facilitating nursing students' placement learning and professional development, pp61-67, Copyright (2013), with permission from Elsevier

This focus on both a 'doing for' approach and an 'enabling' approach would appear to position the framework and the role of the facilitator somewhere near the middle of the facilitation continuum (Harvey et al., 2002). In the framework by Jokelainen et al.(2013) the combination of the pedagogical and human aspects means that the first element is about knowing the student, both from a personal point of view as well as from a learning needs point of view. The second element is about ensuring that the environment is conducive to learning, that it provides a variety of opportunities for learning from experience, and that it is also personally and professionally welcoming. The third element about co-working and encouragement encompasses working alongside the student guiding and teaching by showing, explaining, listening and advising.

On the human approach side it also includes building confidence through encouragement, facilitating discussions to clarify worries and unclear issues, and allowing the student to develop at their own pace. The fourth element is the ongoing assessment of achievement, which covers feedback on performance and the achievement of learning objectives, and on the human side achievements in capability and professionalism (Jokelainen et al., 2013). The facilitator's role of developing a relationship with the person they are facilitating, ensuring an appropriate learning environment, and effectively facilitating learning are found in many other examples about facilitating learning (Sanderson, Lea, 2012, Needham, McMurray & Shaban, 2016).

The element in the framework by Jokelainen et al. (2013) that it could be suggested is slightly out of synchronicity with the others is the 'assessment' element. Whilst it can be agreed that feedback is an essential aspect of learning, and the authors mention the importance of 'objective, honest, positive and constructive feedback' (p65), they then spend quite a long time recounting the mentors' views on giving 'negative' feedback and 'fail' grades. This may be due to the anxiety that having to provide negative feedback engenders in many people, but it also raises the question of the appropriateness of the same person being responsible for facilitating the learning in a trusting relationship and also undertaking a formal assessment of that student. It is recognised that the requirement for assessment was part of the role of the mentor (Nursing and Midwifery Council., 2008b), however if the student feels that the

relationship with their mentor will in some way influence their assessment, this role conflict is likely to interfere with the 'safe' learning environment, and therefore impact on their learning. It is encouraging to see that in the latest iteration of standards for education and training from the Nursing and Midwifery Council (UK) the roles have been split, and students now have Practice Supervisors to support their learning, and Practice Assessors to assess their competence (Nursing and Midwifery Council., 2018)

To maintain a learning environment when working with groups the facilitator role also includes the management of group dynamics (Haith-Cooper, 2003). In the rating scale to test the skills of facilitators of interprofessional education (IPE) that was mentioned above (Sargeant, Hill & Breau, 2010) the remaining three items on the scale are to do with the role of the facilitator and involve setting the scene, role modelling, and creating a learning environment. Interestingly three further items that were removed from the scale due to a low response were to do with group dynamics and managing differences of opinion and conflict. The low response was attributed to them being tested in short workshops, so the skills were not needed. The authors recognise however, that in a different group with a different make up of professionals then the results may be different. The importance of being able to manage the group is also highlighted by Derbyshire et al (2015) who considers that sustaining group culture using group dynamics theory is part of the overarching category of transformational IPL leadership when considering their role adequacy as facilitators. The importance of the group knowing each other and having mutual respect is illustrated by the only two workshops described by Ruiz et al.(2013) above that consisted of student-driven interactions rather than facilitator-driven interactions. These workshops differed from the others in that the students in these workshops knew each other well and had worked together a lot. This lends weight to the argument that a safe environment and a trusting relationship is essential for effective learning. Rowan et al.(2007) suggest that a student-centred learning environment is safe and supportive but academically challenging.

The importance of developing a trusting relationship to enable facilitation cannot be underestimated. Maslow in his Hierarchy of Human Needs (1943) states that the need for physical and psychological safety must be satisfied before any higher level of achievement can be met. Maslow does go on to qualify that by saying that most people

will actually have a slow emergence of a new need, which might explain how people can learn even in a new relationship where trust hasn't developed. However, even when facilitating learning in a classroom, if the students do not feel safe they are unlikely to participate freely and their learning will therefore be affected. This has additional implications for facilitators as demonstrated by Sanderson & Lee (2012). They report how there was also a need for them to take on a pastoral role with the students as they were a long distance from home on their rural placement. This role was suggested by one of the facilitators as being something akin to a 'parent figure' (p336) where they were sorting accommodation and ensuring that the students were eating properly. It is another example of satisfying the need for physical and psychological safety prior to expecting a great deal more.

Whilst it may be difficult to develop a trusting relationship immediately it is important that there is at least mutual respect. Respect can be afforded for a variety of reasons, and Moriarty et al.(2007) describe the mutual respect between new 'insider' facilitators and their work colleagues. The colleagues afforded respect to the facilitators because of their clinical credibility, and the facilitators afforded respect to their colleagues because they knew what their colleagues went through every day (as the facilitators were doing the same job part-time). Hsieh & Knowles (1990) have specifically considered the relationship between registered nurses and their student during preceptorship. They found that trust, realistic expectations, an effective support system, honest communication, mutual respect, encouragement, and mutual sharing were all important. These seven expectations applied to both the relationship between them as well as to themselves as individuals. Thus they found that when the preceptor was open, confident and supportive an anxious student fared much better.

A facilitator working with staff in the work environment (as opposed to a classroom) has to be able to adapt their role so that it works in the 'messy' world of practice. This was demonstrated by a facilitator in an external role during a practice development programme that was aiming to reduce the use of restraint in a nursing home (Dahl et al., 2018). Without a hierarchical relationship between the facilitator and the staff the facilitator built the relationship based on trust. The staff felt that their experiences were acknowledged and their feelings of frustration when things didn't go according to plan were recognised and understood. They also valued the feedback from the facilitator.

Key to the success was the ability of the facilitator to adapt to the fluctuating circumstances within the work environment, enthuse the staff and suggest possible options. Similarly in a facilitated learning programme in practice Bunniss et al.(2012) describes how it was feeding back the results of a questionnaire that enabled the team to discuss results and prioritise areas for improvement. The team was then facilitated to develop action-plans to identify practical steps they could take. What is important in this programme was that it was the team who defined the nature and focus of the work they wanted to undertake to improve things in the practice. The role of the facilitator was to facilitate the group work and break down hierarchical barriers to enable them to do this. Not all facilitators in clinical practice work in this way, and an example of a facilitator role that is closer to the ‘doing for’ end of the continuum was provided by Kelly et al. (2002). They undertook action research to introduce and evaluate a clinical practice facilitator. The goal of the clinical practice facilitator was set very specifically to support both healthcare assistants and newly qualified registered nurses to enhance their competence and clinical skills. In the event their role expanded and they were accessed for skills and clinical teaching, ward teaching, career advice, advice and support for both educational and practice issues, and providing cover on the ward/unit.

## **Summary**

The role of the facilitator is therefore about having a purpose, setting up and maintaining the learning environment, which includes relationships and group dynamics, and managing the learning process. Effective facilitators are able to vary their role according to the purpose and the needs of the people they are working with. This role can vary from doing things for people to enabling them to do it for themselves.

## **The Facilitator as a Person**

A mix of personal attributes are considered essential in the facilitator eg. Empathy, congruence, positive regard (McCormack et al., 1999, McCormack, Garbett, 2003, Titchen, 2003, Rogers, 1983, Shaw et al., 2008), a positive attitude and enthusiasm (Jokelainen et al., 2013, Papinczak, 2010), and knowing and understanding themselves

(Dickson, Walker & Bourgeois, 2006). In addition, knowledge of the process (Rogers, 1983, Needham, McMurray & Shaban, 2016, Harvey et al., 2002), personal, interpersonal and group management skills (Harvey et al., 2002, Needham, McMurray & Shaban, 2016), and maintaining up to date research and clinical knowledge (Needham, McMurray & Shaban, 2016) are also considered as essential skills. Facilitators who were motivated to help colleagues to learn in work did so for a variety of reasons. Some were sought out for their expertise and asked for help, but most of the other reasons were logistical and logical in that there were challenging tasks to be done and the person tasked with doing them needed advice and support to accomplish them (Ellinger, Cseh, 2007). Some facilitators however, were motivated by altruistic reasons of just wanting to develop others (Clouder et al., 2012), and others were motivated by getting to know students, watching group processes evolve and observing students acquiring knowledge (Slattery, Douglas, 2014).

The different approaches to facilitation are not only related to the work in hand, or to the facilitator's range of skills, but also involve the facilitator as a person. In the same way that the learner is affected by their values and beliefs, anxieties surrounding learning, and the provision of a safe learning environment, so too are facilitators. Marshall and Gordon (2010) provide a very simple example of how the actions of a facilitator are affected by their beliefs. They describe how mentors who are meant to arrange for their students to spend time in an interprofessional learning (IPL) situation simply won't arrange any suitable opportunities if they don't see the point of IPL.

The impact of deep-seated values and beliefs can influence whether or not the 'facilitator' is able to engage in a facilitative approach at all. Gilmartin (2001) explored how teachers understood and managed the facilitation role when teaching interpersonal skills to pre-registration student nurses. She carried out the work through in-depth interviews with the teachers and explored their background, their beliefs about teaching in general and interpersonal skills in particular, as well as the current teaching methods that they use. Teachers with type X facilitation styles believed in the need for authority and power in the classroom, and also believed that the students benefitted most from the teacher's expertise. Their style was conventional/theoretical, with a closed, authoritarian, detached, critical and inflexible communication style. In their classroom theoretical ideas dominated, feelings were ignored, and the students' power

was low with no responsibility for organising learning. This was in marked contrast to teachers with a type Y facilitation style. Teachers with type Y facilitation styles identified the significance of using humanistic principles in learning (Rogers, 1983). They used a wide range of activities in their facilitation and were positive about developing insights through rigorous debate (Freire, 1996). Their style was experiential and creative, with an open, involved, flexible and committed communication style. In their classroom they had a balance between theory and emotions and encouraged student-initiated responsibilities. Whilst the study would have been improved by actually observing the teachers facilitating the learning in the classroom - a point which Gilmartin (2001) acknowledges - her work suggests that a teacher's values, beliefs and prior experiences all impact on their facilitation style.

The loss of control and subsequent anxiety as to whether students are achieving all their learning outcomes is picked up in a few studies (Lekalakala-Mokgele, 2006, Moore, 2009). Wanting to 'teach and talk', the lack of guidelines and structure, feeling deskilled, vulnerable and frustrated led to negative emotions with a lack of knowledge instilling fear and fearing loss of control (Rowan et al., 2007).

Learners were also unsure and this led to them being angry at the change in teaching method and this in turn caused the facilitators additional anxiety (Lekalakala-Mokgele, 2006). Moore (2009) undertook a qualitative grounded theory approach to explore the role of lecturer as facilitator. Her methods included non-participant observation followed by semi-structured interviews. The emphasis was to explore the relationship between the lecturer's observed behaviour and their stated beliefs and understanding of the process. Moore recognises that the lecturer's interpretation of the correct way to facilitate was very dependent on their pedagogical beliefs and values. Key features of the lecturer's behaviour that supported their role as facilitators included demonstrating that they 'valued' the student through both their non-verbal behaviour and their "affirmative and positive reinforcement" (p152). Moore (2009) found that the most facilitative lecturers used both power and direction in a covert way to ensure the students reached their "destination" and achieved all the learning outcomes. However, there were also examples of lecturers who demonstrated non-valuing and the use of overt power and direction in their facilitation work. Whilst the anxiety as to whether students will achieve their learning outcomes when being facilitated is mentioned



above, the suggestion from Moore is that the use of covert power and direction is acceptable. I would challenge this however as I believe that this might fall into the manipulative form of facilitation that Heron (1999) refers to. The consideration of power is not inappropriate however, and in a similar way as a lecturer and students, the facilitation role in the study by Mulcahy et al (2018) was seen as a leadership function and therefore potentially had more power. They are very explicit however that this was not about being directive or exerting control over the group, but rather helping the group to come to its own solution (Mulcahy et al., 2018).

Other things that impacted on the ability of facilitators to work effectively were how safe *they* felt in the facilitative learning environment. Papinczak et al (2010) carried out an evaluation of facilitators with both student and tutor focus groups. They identify that all the tutors had been evaluated at least 4 times over the course of a two-year period, and the researcher reports that perceptions of mistrust and confusion were threaded throughout some of the evaluation work. The tutors felt that the University must be looking for some 'ideal' type of facilitator and therefore felt that it was important that there was a uniform approach to PBL where everyone follows the same process. The idea behind wanting a uniform approach was their belief that because some tutors allowed students to cut corners, the students then resented (and poorly evaluated) the tutors who were following the proper process. However, adopting a uniform approach would prevent tutors being able to adapt their facilitation style according to the groups they were facilitating which has been identified as one of the key features of effective facilitation. Interestingly the students felt there was no ideal type of facilitator and agreed with previous literature that it was more important for the tutors to be flexible or adaptable, and more like a member of the group. This also raises questions about the effectiveness of the learning relationship between the tutors and the students, when there was this level of mistrust.

## **Summary**

This consideration of the facilitator as a person emphasises that their values, beliefs and underlying philosophical position is a key first step towards facilitative success. Values and beliefs are deep seated and are often related to whole life experiences, so

changing from teacher to facilitator involves more than just learning a new method of teaching.

## **Frameworks for Facilitation**

Facilitation has so far been described as a variety of processes, skills, attributes, and roles. Holding all of these together in some form of framework makes them easier to understand, can define relationships between concepts and gives them a coherent whole. Whilst some of the frameworks identified in the literature are about the role of the facilitator (Jokelainen et al. 2013; Lekalakala-Mokgele & du Rand 2005), others have a broader focus on the whole process of facilitating learning (Chabeli & Muller 2004; Titchen 2000) or facilitating critical reflective practice (van Aswegen, Brink & Steyn, 2000), whilst others state their focus is facilitating practice development (Hardiman & Dewing 2014). One framework is potentially transferable and useable in many different situations and in combination with other frameworks (Heron 1986).

This section will consider six different facilitation frameworks with the use of visual representation of the model where possible. All these frameworks describe facilitation that has elements in common with those described in this literature review. The majority of the models state that they are designed to be used as guides and supports to help facilitators in their work rather than as rigid frameworks.

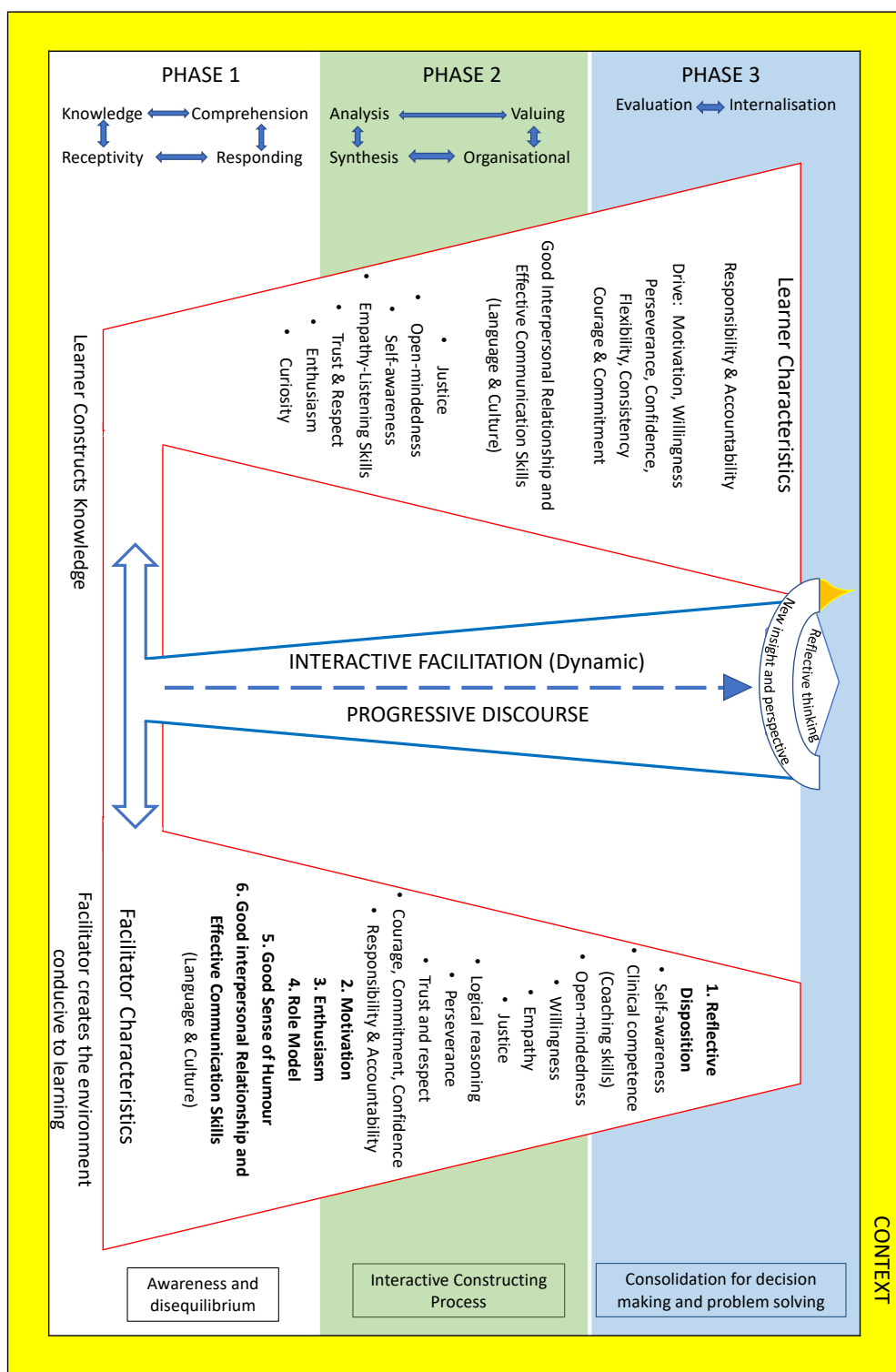
### **1. A model to facilitate reflective thinking in clinical nursing education**

Chabeli and Muller (2004) developed a model to demonstrate how reflective thinking of learners in clinical nurse education can be facilitated. The model was developed through four phases – a concept analysis based on relevant literature of reflective thinking, which provided direction for a focus group with twelve nurse educators. The focus group identified *how* the educators thought reflective thinking could be facilitated. The identified concepts and sub-concepts were then conceptualised, and the relation statements provided the basis for the model development which was then evaluated and refined by experts. The quality of the copy of the original paper makes it difficult to see the development of the model, however with the parts that are visible

and the description of the model within the paper I have created the composite model seen in Fig 2 below.

In their model the context is clinical nursing education and the facilitator is the agent who, through a dynamic process of interactive discourse, creates an environment suitable for reflective thinking. The facilitator should possess many of the skills and personal qualities that were identified above from the literature. The facilitator is linked to the learner who should also possess a large number of skills and attributes to enable them to take advantage of this way of learning and drive the interactive process in order to gain clinical knowledge and skills. The two triangles (representing the learner and the facilitator) that make up the centre of the model are positioned so as to illustrate how as the learner increases in knowledge the facilitator reduces their input. Initially the facilitation is mostly instructional and less discursive, but this develops to “dialogical reasoning, co-operative and collaborative learning” (p57) where the learner is self-directed, can solve problems and make rational clinical decisions. The ‘lamp’ at the top of the blue inverted triangle represents the level at which reflective thinking is said to have taken place. The lamp signifies the “bright, holistic and comprehensive nature of the clinical nursing education perceived by the learner” (Chabeli and Muller 2004 p58).

The whole process takes place through three phases of reflective thinking which are marked on the side of the model and illustrated through the three colours (white, green and blue). These colours, and the yellow colour of the context, are all selected deliberately by Chablei and Muller (2004) to very creatively link with the colours of de Bono’s hats (2000). Yellow = positive, optimistic and constructive; White = basic knowledge such as facts, concepts, principles & theories; Green = creative interacting to generate new insight and perspective; Blue = cool and in control, able to think about thinking.



\* The illustration of the model in the scanned copy of the paper is of too poor quality to be reproduced exactly. This model has therefore been developed from the parts of the model that are decipherable and the description of the model in the body of the paper

Figure 2. My interpretation\* of A Model for Reflective Thinking (Chabeli and Muller 2004 p55)

Whilst the development of the model is theoretically rigorous, and the role, skills and attributes of the facilitator match those identified in this literature review, the model does seem to depend quite heavily on the learner, and their ability to develop the necessary skills and attributes to take advantage of this way of learning. The difficulties that learners have in changing from traditional learning to facilitated learning suggests that this model will take time to introduce and work through developmentally with the learners. This would appear to make the model more suitable to a nursing curriculum rather than one-to-one facilitation. Chabeli and Muller (2004) developed their model from the literature and a focus group of educators, and they identify that the model still needs to be implemented, tested and refined. Although I could find no reference to this model being implemented in practice there are a number of papers that have the involvement of the same author and are considering the difficulties in facilitating critical reflective thinking (Mangena, Chabeli, 2005, Waterson et al., 2006b, Waterson et al., 2006a, Chabeli, 2006) which suggests that whilst it may not have progressed beyond this development phase, some work may be ongoing to refine it.

## **2. A model for facilitation in nursing education**

Lekalakala-Mokgele & du Rand (2005) developed their model for facilitation in nursing education from data obtained from facilitators and students in an exploratory and descriptive qualitative research study. They were aiming to develop a model for the process of facilitation in nursing education. It had been recognised that nurse lecturers needed guidelines for facilitation following an extensive change in the nursing curriculum that moved away from lectures to ‘non-traditional’ learning/teaching methods. In addition, the learners were unfamiliar with these teaching methods and were struggling to adapt.

The study used 10 unstructured focus groups (4 with facilitators and 6 with students), and asked the question “How do you experience facilitation as a teaching/learning method?” (p24). The framework of the model then evolved from the experiences of the researcher, the needs assessment, the data from the focus groups and existing literature.

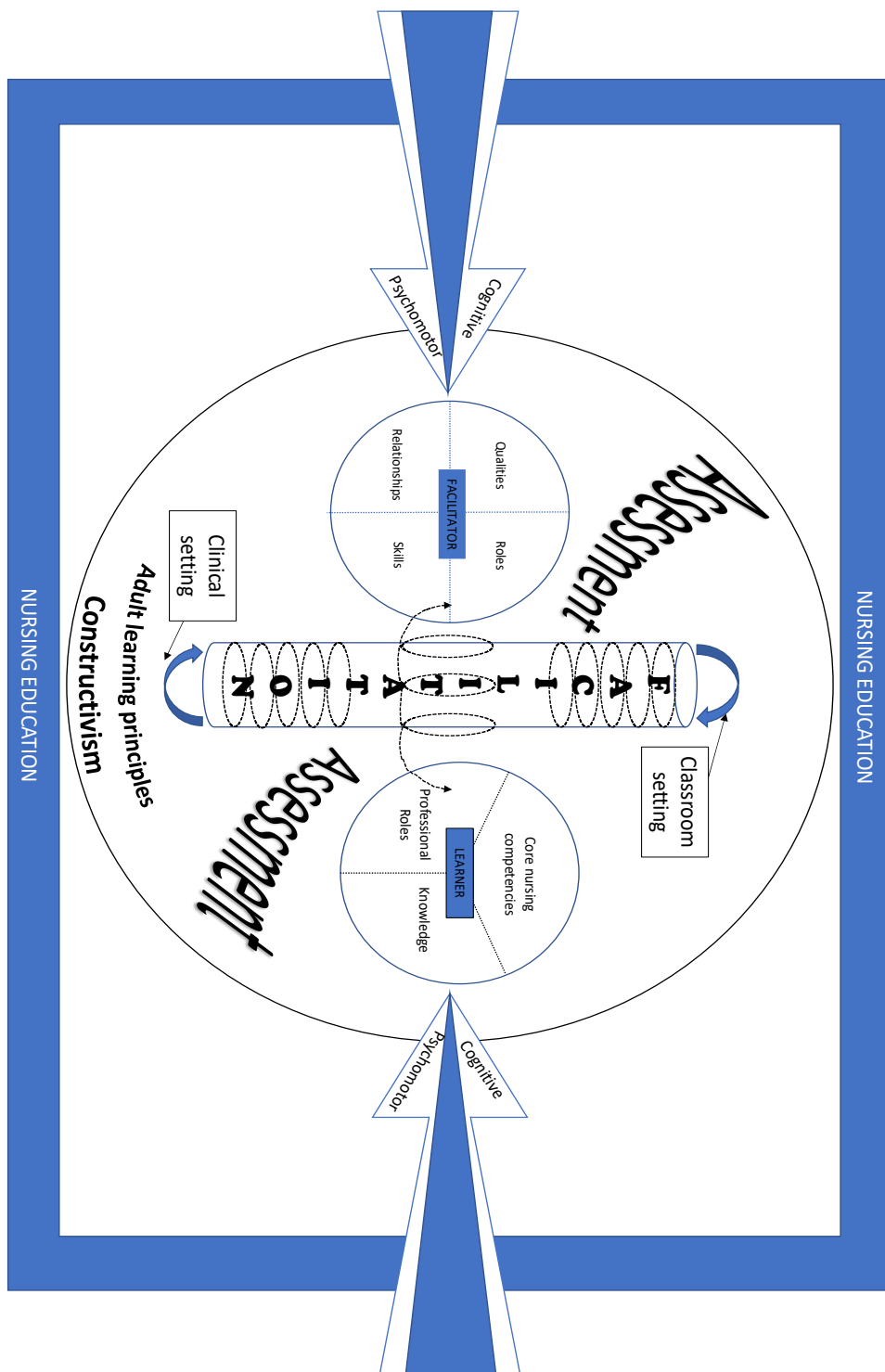


Figure 3. A model for facilitation in nursing education (Lekalakala-Mokgele and du Rand 2005 p28)

The model is underpinned by constructivism and a number of assumptions taken from adult learning theory. The key concepts in the model are the facilitator who is expected to possess certain skills and qualities and undertake roles similar to those identified in

this literature review. Learners are regarded as adults and are identified as needing to learn “nursing knowledge, nursing competencies and professional values.” (p25). Facilitation requires interaction between the facilitator and the learners, using real life situations to ensure the learning is contextual. Learning should lead to cognitive, affective and psychomotor development, and assessment is seen as “essential and necessary” (p26). The authors acknowledge that this model is not intended to be rigidly adhered to, but they believe that at the start of learning to facilitate it may be used to provide structure, gradually reducing its influence as the facilitators’ expertise develops.

Whilst the model appears to have been developed using recognised theoretical methods, the language used in the reporting of the work still suggests that whilst the learners have a variety of things to learn, they are not portrayed as equal contributors to the process. When compared to the previous model (Chabeli and Muller 2004) where the expectations of the learners was quite high and the ‘working together’ notion was highlighted, in this model there is nothing explicit beyond the statement that learning requires the involvement of both learners and their facilitator through the process of interaction. This raises the question of the paradigm shift that is needed when moving from being a lecturer to be a facilitator, and whether or not this model will actually bring about that change in the teachers/facilitators. In addition, the focus on assessment in the model has been highlighted in another paper by the same author (Lekalakala-Mokgele, 2006) as reducing levels of trust between learners and facilitators which again, learning from the literature review, would add potential difficulties to the model.

### **3. A model for facilitation of Critical Reflective Practice**

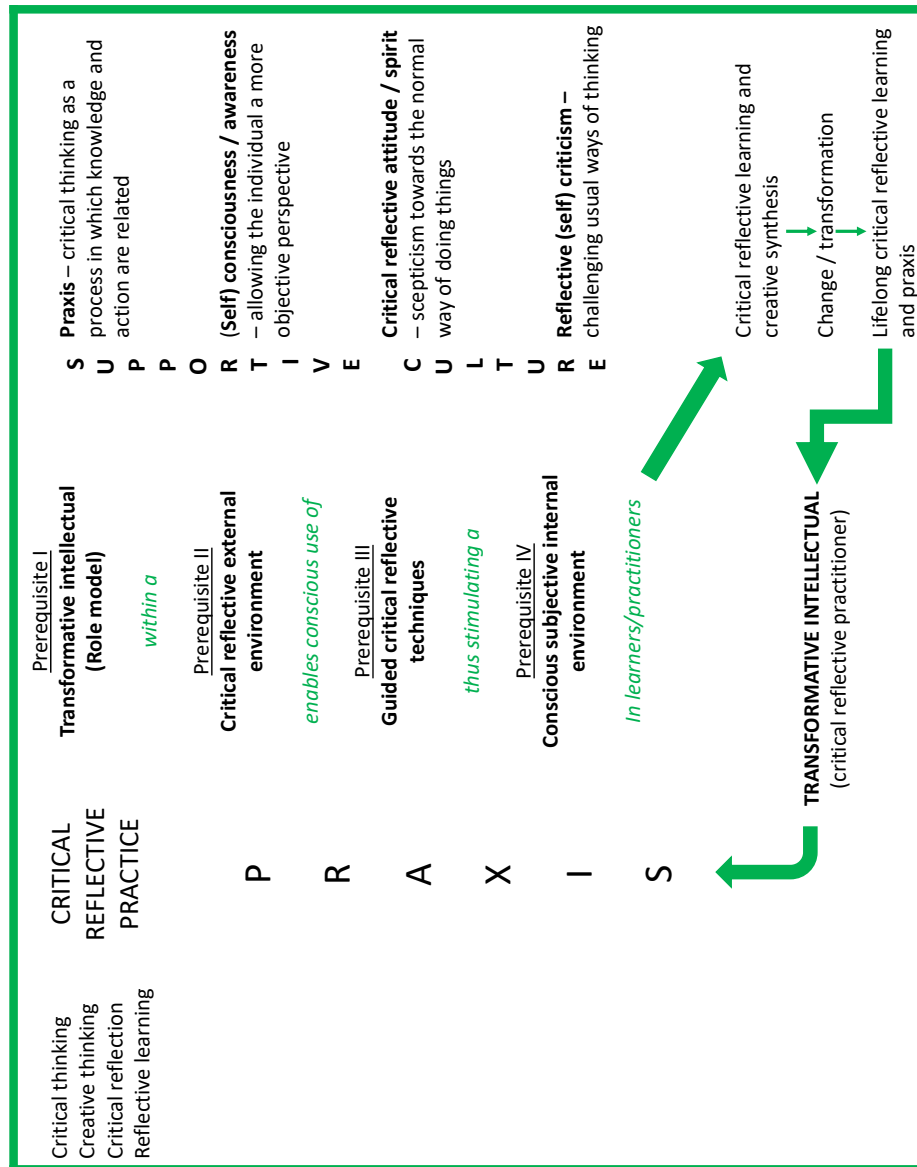
The model for the facilitation of critical reflective practice is described over three papers (van Aswegen, Brink & Steyn, 2000c, van Aswegen, Brink & Steyn, 2000a, van Aswegen, Brink & Steyn, 2000b). The first paper explains the reasons for, and the phases used, to construct the model. The second paper contains the conceptual analysis, and the third paper in the series describes the model. The authors state that the model is based on an in-depth analysis of the literature, conceptual analysis,

development of working definitions and hypotheses, application and evaluation of selected critical reflective techniques in an educational setting, and construction of the conceptual framework. They also believe that the model can be used in any setting which is responsible for the preparation of professionals.

The model has four pre-requisites which sit in a relationship to each other as seen in the visual representation of the model (fig. 4). The main concept of critical reflective practice that is put forward appears to be that of reflecting-on-action (Schön 1983) as the suggestion is for the practitioner to ‘withdraw’ from the issue in order to reflect. It is made up of four building-blocks:- critical thinking, creative thinking, critical reflection, and reflective learning. The authors describe these four blocks as being habitually inquisitive; able to see problems and flexible in thinking of innovative solutions; willing to take risks and challenge the status quo, particularly the validity of previous learning and the realities of practice; and make new or revised interpretation of the meaning of the experience. In addition to the main concept and the four building blocks for the main concept, there are eight supporting main concepts, and thirteen relating concepts, making 26 concepts in total. This makes the model particularly complicated to keep at hand as a working model.

Despite the model being titled ‘facilitation of critical reflective practice’ there is not really any mention about someone being in a specific facilitator role, but rather the practitioners themselves are seen as ‘experienced role models’ and are tasked with ‘empowering’ others by facilitating critical reflective practice in developing practitioners (van Aswegen, Brink & Steyn, 2000b) .





### Relating Concepts

Empowerment :

Caring :

Challenging :

Proactive :

Transformative :

Visionary :

Motivative :

Autonomy :

Reflective withdrawal :

Learned conversation with the self :

Re-entry :

Regulation through choice :

Supportive culture

\* The illustration of the model in the scanned copy of the paper is of too poor quality to be reproduced exactly. This model has therefore been developed from the parts of the model that are decipherable (van Aswegen et al 2000a) and the description of the model in the body of the paper by van Aswegen et al (2000c)

Figure 4. My interpretation\* of “A model for facilitation of Critical Reflective Practice” (van Aswegen et al 2000a p 119)

The three different models mentioned above have similarities in their construction, presentation and publication. They are all published in *Curationis*, all in South Africa, and two of the three (Chabeli & Muller 2004; van Aswegen et al 2000) use the same practice theory (Dickhoff, James & Wiedenbach, 1968) to construct their conceptual framework. Despite the similarities none of the papers cite each other. In addition, all the papers seem light on references to support their concepts despite all suggesting they had undertaken extensive literature reviews at the start of their work. The similarity in all three papers in this regard may suggest that this is something related to the publication rather than the individual author. It would also be difficult to repeat the model development as the papers do not illustrate which findings came from the literature and which from their participants. Of these three models only the model by van Aswegen et al (2000c) has been tested in practice as part of the model development. Despite these criticisms, all the models contain elements about facilitation, learning and critical reflection that ring true with the literature that I have read in preparation for this work.

#### **4. The Critical Companionship conceptual framework for facilitation**

Critical Companionship (Titchen, 2003) is a conceptual framework that emphasises the facilitation of learning from clinical practice and at the same time the creation of new knowledge about facilitation through critical reflection between the practitioner and an experienced facilitator. It is therefore designed to develop a nurse's clinical and facilitation expertise through experiential learning. The framework was developed, tested and refined during an action research study and links the four theoretical perspectives of critical social science, humanistic existentialism, a spiritual (but not religious) perspective, and a phenomenological perspective. This results in the critical companion being concerned with the learner's lived experience of learning and of practice, valuing the learner for who they are, and helping them to reach their full potential by supporting critical reflection integrated with practice.

Critical companionship starts in the centre with the relationship between the critical companion and the learner. As you move outwards in the framework the domains are developed. In this framework a domain is "a collection of different kinds of knowledge

that have a conceptual connection” (Titchen 2003 p35). The framework also contains strategies for putting the domains into practice. The strategies and domains fit with the process, roles and skills of facilitation identified in this literature review. Titchen (2003) identifies that Critical Companionship is not a prescriptive model, but is rather a “metaphor and framework to provide inspiration and practical principles for individuals to develop their own unique forms of Critical Companionship” (p40).

The first domain is the relationship domain (dark green) which contains four process concepts mutuality, reciprocity, particularity and graceful care. Overall the domain is about working together in a carefully negotiated relationship and providing specifically tailored support. The second domain is the rationality-intuitive domain (light blue) which has the three process concepts intentionality, saliency and temporality within it. These are practical tools for realising the relationship and facilitation processes and have added a rational aspect to the oft tacit intuitive element of expertise. Next to this domain are the strategies needed to put the processes in the first and second domain into action (orange). Outside these strategies is the third domain which is the facilitation domain (dark red) and contains the process concepts of consciousness-raising, problematisation, self-reflection and critique. This domain is about raising the practitioners’ awareness about their existing knowledge and the effect of that on their practice; helping the practitioner to see problems in practice that they have taken for granted, supporting critical reflection on situations and events and a collaborative process of exploring the issues and meanings underpinning and influencing the situation. The strategies to realise the facilitation domain (light green) are articulating craft knowledge, observing, listening and questioning, feedback, high challenge/high support, critical dialogue and role modelling. The fourth and final domain is the facilitative use of self (dark blue) where the facilitator uses the self and professional artistry to blend all the domains, strategies and processes together to get the best outcome for the practitioner. Within Critical Companionship there are therefore eleven process concepts divided into three domains, and one overarching domain that ties the others together.

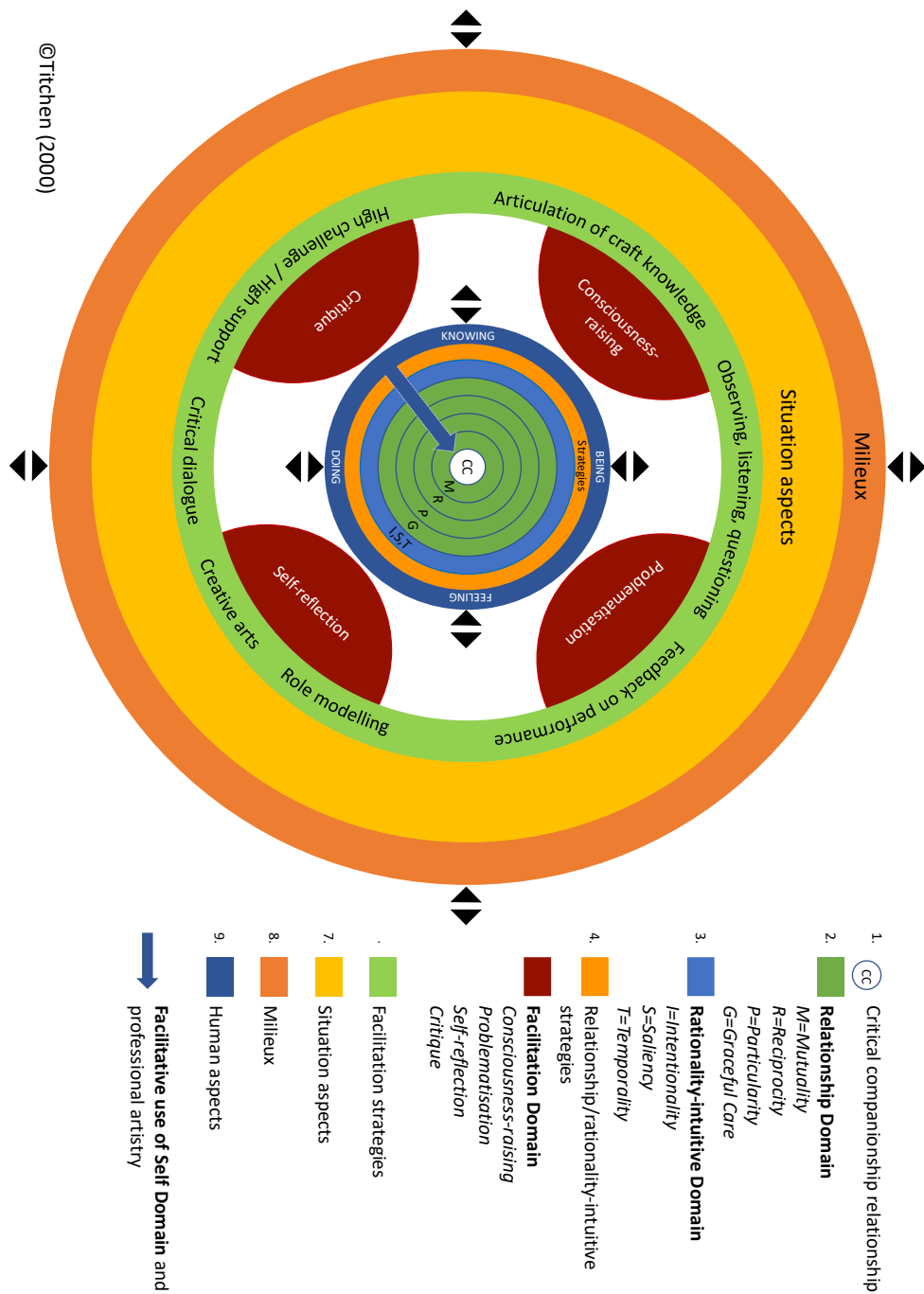


Figure 5. The Critical Companionship Conceptual Framework (Titchen 2003 p35)<sup>2</sup>

<sup>2</sup> Reprinted from Nursing Standard; Vol 18 / edition 9; Titchen,A.; Critical Companionship: Part 1, pp33-40 Copyright (2003), with permission from RCN Publishing Co.

Critical Companionship has been used in a variety of situations from practitioners working one-to-one with each other so that the more experienced can help the novice to develop facilitation skills (Gribben, Cochrane, 2006), to large national projects where expert nurses were helped to surface and evidence their expertise (Manley et al., 2005). With the exception of these projects Critical Companionship remains surprisingly little used in practice. It could be suggested that this is because the framework is perceived as being theoretical rather than practical, and as such it is often referred to as being particularly complex (Dewing, Wright, 2003, Gribben, Cochrane, 2006). In addition, there is the suggestion that you need to be an expert facilitator in order to be a critical companion, and expert facilitators are difficult to find in practice with people being reluctant to identify themselves as such. It may even be that its name doesn't really describe what it does and to an inexperienced person may be seen as something of an oxymoron (Brown, Harrison, 2009). Once the framework is understood and embodied however, it provides a very complete way of understanding and guiding the process of holistic facilitation and has been described as a powerful tool to develop clinical supervisors and enable a shared journey to flourishing (Mackay et al., 2018).

## **5. Critical Ally and Critical Friend**

This paper describes the early development of two models by Hardiman and Dewing (2014) that can be used to develop expertise in facilitating practice development. The models have been developed from the literature and the personal experience of one of the authors and are currently being tested in practice. The authors state that the two models are sequentially related to Critical Companionship, but because of the complexity of that model these have been developed with novice and proficient facilitators in mind. The models therefore have similar overall intent, but differences in the level of complexity in each of the domains and the elements within those domains.

The aim of the Critical Ally relationship is to “enable a novice practitioner to learn in and from practice in their workplace and, at the same time, help a novice facilitator to become more skilled in facilitation” (p6).

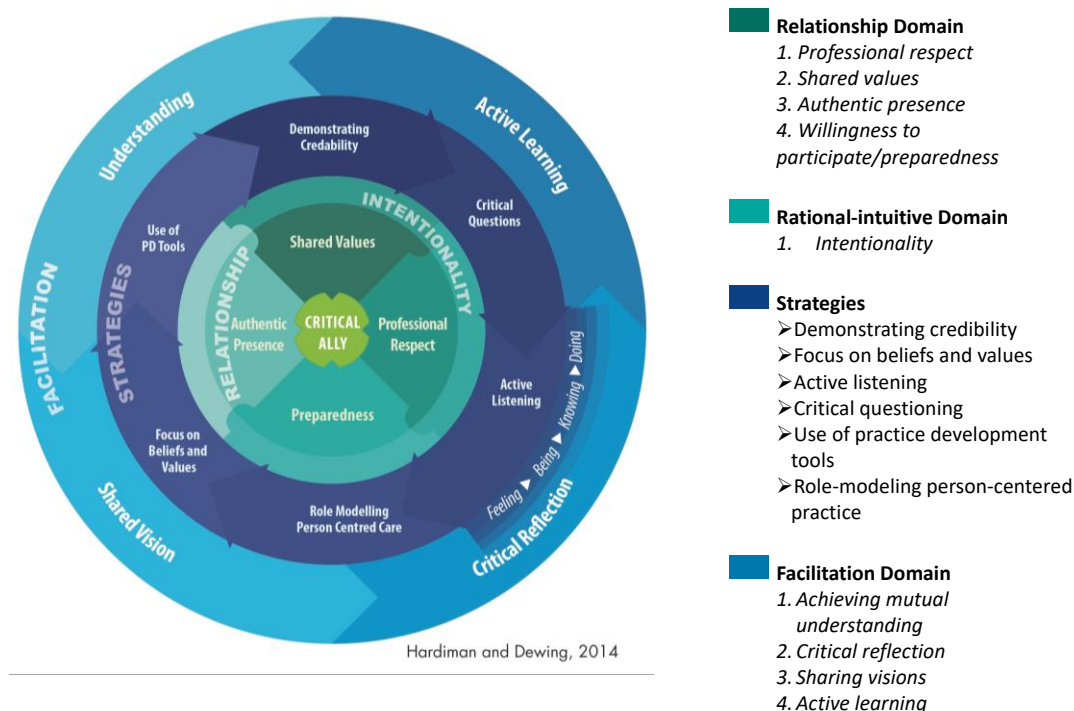


Figure 6. Critical Ally (Hardiman & Dewing 2014 p7)<sup>3</sup> with list of domains added

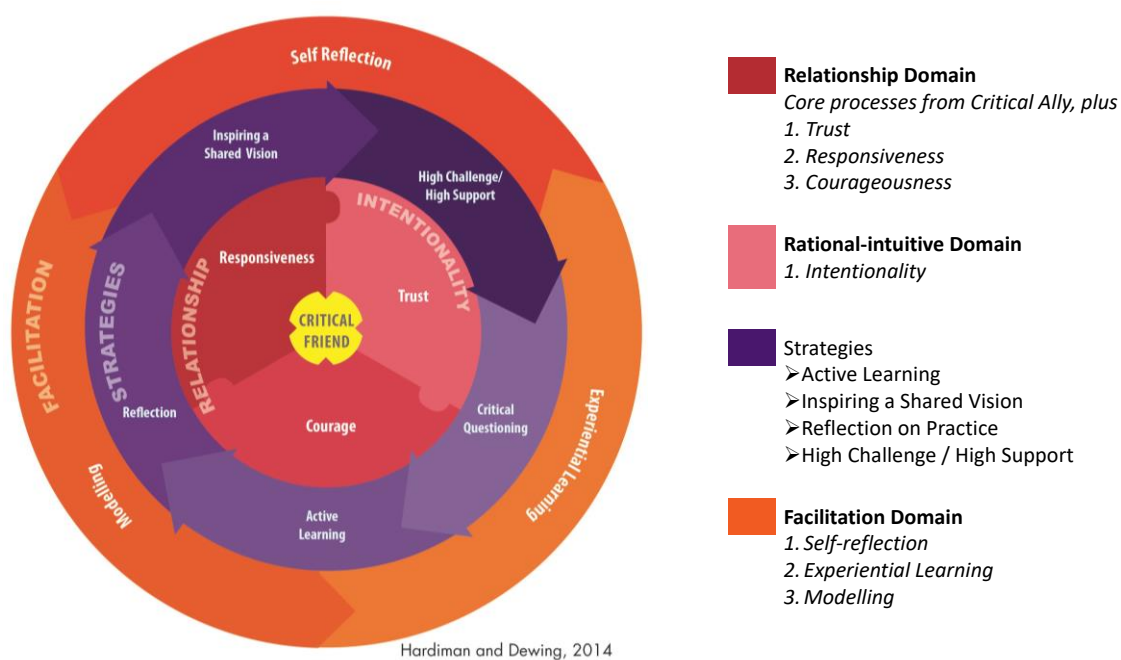


Figure 7. Critical Friend (Hardiman & Dewing 2014 p12)<sup>3</sup> with list of domains added

<sup>3</sup> Both models reproduced here with the kind permission of the author Michele Hardiman.

The Critical Friend model is “the next stage of the facilitative relationship, where the practitioner has developed an enlightened and reflective consciousness of their practice and expressed a desire or intention to further develop their own facilitation skills” (p12). The authors state that the idea behind the models is to develop a knowledge and skills pathway with people ‘evolving’ gradually from one model to the next. However, it has to be questioned whether people will in fact ‘evolve’ or will they simply stick with the framework that they know, a fact acknowledged by the authors. The models also seem to be much more ‘practical’ than Critical Companionship, which may indeed be the intention bearing in mind their desire to make them more applicable for use by novices. As stand-alone models for facilitation and developing facilitators they initially appear easy to understand and contain a lot of the facilitation processes identified in the literature. However, they also refer to a number of other tools and frameworks that are not contained in the specific facilitation of learning literature eg. Use of ‘PD’ tools, role modelling person-centred practice, active learning. It has to be questioned then whether these models can stand alone as guides to facilitation or whether they can only be used for facilitating a particular type of practice development and in conjunction with an understanding of the other literature eg. the person-centred practice framework (McCormack and McCance 2016), active learning as described by Dewing (2010), and practice development tools as described by Dewing et al (2014).

## **6. Six Category Intervention Analysis**

The six category intervention analysis (Heron, 1986) is the only framework here that does not have an accompanying visual representation. It focuses on one-to-one interventions between a practitioner (anyone who is offering a service to a client) and client (a person who is freely choosing to use the practitioner’s service to meet a self-identified need). Although the interventions were developed for therapeutic use they can also be used for the work between a facilitator and learner and is one of the most commonly used frameworks for facilitation.

The six categories have been divided into two groups of three interventions. The first three are classed as ‘Authoritative’ interventions because the facilitator is taking responsibility for the learner.

- a) Prescriptive interventions – directing the behaviour of the learner
- b) Informative interventions – imparting knowledge and information to the learner
- c) Confronting interventions – raising awareness of a limiting behaviour which the learner is not aware

The second group of three interventions are classed as ‘Facilitative’ interventions because they are enabling the learner to be more autonomous and take more responsibility for themselves.

- d) Cathartic interventions – enable emotional discharge
- e) Catalytic interventions – enable self-discovery, self-directed learning and problem-solving
- f) Supportive interventions – affirm the worth and value of the learner

Heron feels that whilst both sets of interventions are valid, the most important thing is the balance between them and the recognition of the appropriate use of power in the relationship. Heron describes three types of power – autonomous power in the learner, co-operative power shared between the facilitator and learner, and hierarchical power of the facilitator over the learner. He also describes how the facilitator chooses which interventions to use depending on the learner and their individual needs thus demonstrating facilitator flexibility. The initial framework of the six interventions appears relatively straightforward to use even for novices, although the many iterations of the framework when different people use it in different situations has led to a degree of misunderstanding of the interventions. These can end up being replicated and magnified as people re-interpret and secondary reference. However, Heron is quite explicit that this framework is not set in stone and can be adapted and used as needed. He doesn't see why people would want to though as he has confidence that the six categories cover almost every type of intervention that may be needed (Heron, 1986). The full framework extends into interventions when they go wrong and become degenerate and perverted, however it is the simple initial framework that is in widespread use.



The framework has also been used in practice between a nurse and patient, and an example of this is from midwifery where Tennant and Butler (2007) have used Heron's framework to consider communication and relationships and the concept of 'partnerships' between midwives and the women they look after. It has also been suggested that Heron's interventions can be used by a critical companion in a one-to-one situation (RCN Institute, 2007). It would appear that it is the lack of a fully developed framework for facilitation that makes Heron's six categories of interventions so adaptable and so useable in different situations.

This exploration of six facilitation/learning frameworks has identified that the majority were developed from the literature, although most have gone on to be tested in practice. It is not surprising therefore that they correspond so well with the findings in this narrative review. As yet no-one appears to have published their model again following testing to identify which parts of the original did not work and why. Theoretically the most developed and tested is Critical Companionship (Titchen 2000).

## **Summary**

Registered Nurses are expected to be life-long learners, however all too often they are working in organisations where there is a dissonance between this expectation and the provisions that the organisation makes to achieve it. Learning in work is seen as the obvious solution, however for many organisations learning in work is seen as simply training. Higher Education Institutions have taken on board the ethos of work-based learning and now provide many courses based on these principles. However, these courses last for a relatively short period of time, require the learning to be formally assessed, and don't necessarily result in a change of practice.

In work-based learning a facilitator is seen as an important factor. Reading a variety of literature about facilitation shows that the key roles of a facilitator are around setting up and maintaining a learning environment and managing the learning process. The key interventions in the facilitation process are related to various forms of interaction and communication between the facilitator and the learner. The values, beliefs and underlying philosophical position of the facilitator are key to their way of being and

therefore their way of facilitating, but effective facilitators are able to adapt their style and their role to meet the needs of the person or group they are working with.

Through doing this narrative review I have identified that whilst there is literature about how to facilitate learning in the classroom, there is not a great deal of literature about how registered nurses who are not undertaking academic courses are actively facilitated to learn through their everyday practice. In addition, whilst there is a lot of literature that is evaluating the delivery of academic WBL courses, there is very little that aims to understand WBL that is not associated with academic courses.

The existing frameworks for facilitation are also not specifically related to facilitating nurses to learn through their work, although the Titchen model of Critical Companionship (2000) would appear to be the most useful in this respect. I believe that this lack of knowledge lends weight to my initial query about the REACH programme and therefore requires further investigation.

In the next chapter I will set out in detail the philosophical perspective that will underpin the research and will set the direction for both how I will answer the research questions, and the type of knowledge that I will generate.

# **Chapter 3: Philosophical Perspective**

## **Introduction**

This chapter sets out the key features of humanistic existentialism, hermeneutics, and critical theory, which is the philosophical perspective that underpins the study. The chapter describes how this philosophical perspective impacts on the generation of knowledge, on the decision about what sort of research methodology to use, and on the stance the study will take towards learning. The chapter contains creative work that helps to generate understanding of the concepts being discussed.

Making clear the philosophical intent of the study provides ontological and epistemological authenticity (Higgs, Titchen, 2007) and ensures both rigour (Appleton, King, 2002) and coherence. Clarity about the framing philosophy lends credibility to the published results (Smagorinsky, 2008), and also reduces the risk of using ‘bad’ philosophy (Collier, 1994).

## **Why humanistic existentialism?**

The decision to use existentialism was a personal one. The preparatory work for this study required me to develop as a facilitator, and I used a post-graduate certificate via distance learning to support me with this. This work was truly transformational for me. Rogers (1993) identifies that the change from teacher to facilitator means “uncertainties, difficulties and setbacks”, and I certainly had many of those. I discovered however, that facilitation is about a way of being and not something to switch on and off whenever convenient. The course was therefore about me ‘becoming’ a facilitator, not about ‘doing’ facilitation tasks.

Whilst teaching nurses in the emergency units I had always cared about them. I always made sure they were feeling OK, and I always did as much as I could to support them. The change to facilitator involved a complete change of perspective however. Suddenly I was in a learner-directed process that was focussed on relationships and creating safe spaces for learning. For the first time I really came to know the learners

as people, supporting them to identify what they wanted to learn and how they were going to do it, and then helped them to reach their full potential. I passed responsibility back to the nurses and withdrew (slowly) my paternalistic approach. I started treating the nurses as responsible adults who were able to make their own decisions. In the process of transformation I explored my own values and beliefs and came to a deep understanding of what it means to be authentic – to be in a permanent state of becoming.

This personal transformation took place shortly before I started this research. I realised that in order to remain true to my personal values and beliefs about learning I had to ensure that I was able to follow that through into the research. I explored different philosophies and ‘stumbled’ across existentialism that had in fact been hiding in plain sight. I felt quite excited when reading about it, as it seemed to encapsulate everything that I was experiencing about my changing relationship with those I was supporting to learn. I therefore started to think about how this philosophy could guide the sort of research that I wanted to do.

## **Understanding Existentialism**

Existentialism is a “style of philosophising” rather than a philosophy (Macquarrie, 1972 p2). It denotes a set of philosophical principles that emphasise the individual, his uniqueness and his ability to make informed choices” (Nyatanga, Dann, 2002 p236)

### **We are embodied, intentional beings**

Sartre (2003) believes that there are two modes of being, Being-**in**-itself which refers to objects that have a set appearance that they must represent to be that object and Being-**for**-itself which refers to things that have a self-consciousness. These beings-for-themselves do not have a set nature but are free to make self-determined choices (existence before essence). Although Sartre holds that the two forms of being are separate (Sartre, 2003), a true existentialist position is to view human beings as being both object and subject. The object of a human being is their body, and having a body means that humans are objects like any other object and therefore part of the world

around them. Cooper makes the distinction between an objective body and a lived body, where the objective body is the ‘flesh-and-blood complex’, and the lived body is the living person that inhabits the objective body (Cooper, 1999). The lived body can’t exist without the objective body. The fact that humans have an objective body means that they are a part of the world, responsive to things around them and influenced by all the natural laws that any other object is influenced by (Matthews, 2006). The fact that humans also have a lived body means that they can initiate actions on the surrounding environment to meet certain needs and desires and are therefore intentional (Matthews, 2006). Existentialists believe that whilst other living things might have intentionality, it is the freedom to make choices – a conscious intentionality – that is believed to be the key feature of a human being (Wartenberg, 2008).

### **We live an active, participatory existence**

Existentialism holds that it is not possible to see or understand the world by simply thinking about it, instead, because we are embodied, we have to experience it ‘in action’ (Cooper, 1999). It is this contact with the world through the body that results in things having subjective meanings, so things are not experienced as detached objects, but have a “practical, emotional, sensual and imaginative meaning” (Matthews, 2006 p90). Merleau-Ponty’s (1945) view is that it is only after experiencing the world that we can begin to develop knowledge of it, and only then that we can begin to think of an objective world independent of our experience. The lived body of experience and the objective body of science are therefore just the same body described from two different points of view (Matthews, 2006). Existentialists are therefore interested in the nature of active, participatory existence (Jones, Cardinal & Hayward, 2003), where we experience the world through our senses, and act on what we perceive (Matthews, 2006).

### **We have freedom of choice**

Existentialism holds that humans do not have a pre-defined essence or nature but are free to create their own purpose or essence. Because people have this freedom they are also free to make new choices for themselves, and to remake their “nature” (Barnes, 1961).

This continuous process of making choices means a ‘lived body’ is always in a state of becoming, rather than being in a fixed state (Fontana, Van de Water, 1977). This freedom however is hard work as it is much easier to continue to stay in an old routine, because with freedom of choice comes an element of responsibility, where we become fully responsible for our actions (Fontana, Van de Water, 1977). There is a feeling of security in believing that we are simply following someone else’s orders, as we do not have to feel responsible for what we have done. However, being responsible for our own choices means that we actually have no one to blame but ourselves (Wartenberg, 2008). Freedom of choice is not exercised in a vacuum however as we live in a world with other people. The freedom that is referred to is a metaphysical freedom (free-will) not political freedom (Jones, Cardinal & Hayward, 2003). In reality, choice is usually a process of modifying our existing situation based on what is already familiar to us. Responsible choices have a sense of consistency about them and are not liable to change just on a whim (Cooper, 1999). Existential freedom then is not about continually reinventing yourself, but rather is the power to decide against the current situation, and to begin something else instead. It is also about confronting entrenched ideas and beliefs. We all have this power whether we choose to use it or not, and it is this that makes us all responsible for the stance that we take on things, and for our actions (Cooper, 1999). Existential freedom can therefore be seen as “radical evaluation ... essential to our notion of a person” (Cooper, 1999 p162).

## **We are accountable and self-aware**

Generally people are most comfortable when they are socialised into the norms and values that prevail in society. People can be said to be living an inauthentic life however when they identify too much and too easily with the ‘communal character’ of their existence. In doing so they lose what is unique about themselves and become boxed into unquestioned routines, accept others ideas without thinking, fall into pre-moulded roles, find excuses for their actions, and blame others (Cooper, 1999). This false image is made worse by disassociating themselves from their actions and pretending that their actions do not reflect the real them. Self-deception is an unconscious process, and to avoid it there is a need for constant evaluation as mentioned in the previous section. This evaluation should be an external awareness of

things and our engagement with them rather than an internal one (Cooper, 1999). Focussing too much on the internal aspects encourages an introspective approach to understanding ourselves (Heidegger, 1953). This encourages the belief that the true self is an inner one, hidden by an outer superficial one and perpetuates the self-deception. Instead the true self is the self we should strive to become (Cooper, 1999)

“Man must recognise that he alone determines the values by which he lives, that he is not endowed with a ready-made self or nature but rather must be constantly making himself. He is nothing; he is always about-to-be whatever he chooses (Barnes, 1961 p42).

Authentic people (people who act in “good faith”) do not deceive themselves that they have a determining role or personality, instead they act in the full knowledge and recognition that they have absolute freedom (Jones, Cardinal & Hayward, 2003). They are prepared to stand back from their situation and commitments, calmly to consider these and the alternatives to them, and only then to take a decision for which responsibility is fully accepted (Cooper, 2012). Pursuing authenticity is difficult however because it requires self-reflection, uncovers things that are uncomfortable to know and may cause friction with others (Panza, Gale, 2008). Authenticity is therefore often associated with the idea of commitment or resoluteness (Crowell, 2012).

### **We are unique individuals with a mutual respect for others**

In a relationship between people of good faith (authenticity) mutual respect for each other's freedom becomes a real possibility (Jones, Cardinal & Hayward, 2003). Existentialism is completely opposed to the exploitation of others, because the idea that one group of people are in some way superior to another group, assumes that people are predetermined to be something, and goes against the idea that we are all free to make of ourselves what we will (Barnes, 1961). In the same way Sartre (2007) thinks it is essential to consider our responsibilities when making or acting on moral judgements about another person. The way we treat each other is so affected by our own or others moral judgements, that it is irresponsible to take these judgements unreflectingly for granted (Cooper, 1999). Buber (2002) describes a similar relationship as being an “I-Thou” relationship, which is a relationship of openness,

directness, mutuality and presence that recognises the uniqueness of the other person. It is in contrast to the I-It relationship where one knows and uses other people or things as a means to an end.

## Humanistic existentialism and research

Existentialism has a relativist ontological position where the world is understood by reference to the significance that things have for us (Susman, Evered, 1978)

Worlds and people are what we meet, but the meeting is shaped by our own terms of reference (Heron, 1996 p11)

Existentialist philosophy lays great stress on the process through which we come to understand or to know. It emphasises the effect that embodiment has on the way we experience things - that we can reflect, self-interpret, evaluate and choose (Susman, Evered, 1978). Language is the way we express these experiences (Macquarrie, 1972), and this enables the knowledge to be accessed.



*Figure 8- Existentialism - Understanding is developed from data that is obtained via the senses, which is then interpreted and given meaning.*

Experiential knowing is knowing an entity – person, place, thing, process etc – through face to face meetings and interaction, and it cannot be fully reduced to a set of descriptive statements (Heron, 1981b). Understanding develops through reflection and interpretation of the experience. Because we cannot separate ourselves from who we are, all interpretations are located in a particular context, setting, and moment – our ‘being-in-the-world’.



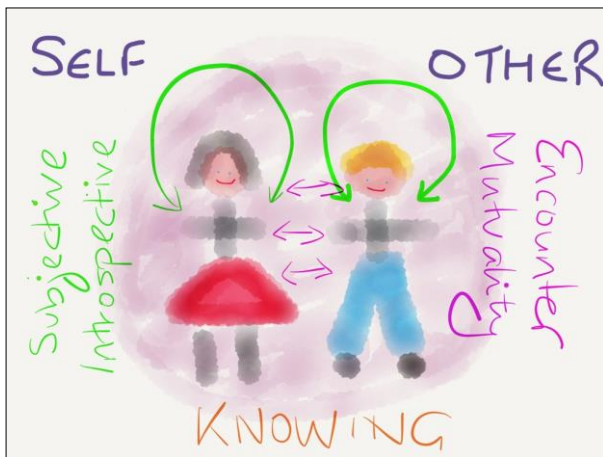


Figure 9- Existentialism - The act of knowing is grounded in subject-subject relations

Knowledge is developed when a person takes their own subjective and introspective understanding, and through an encounter with another person engages in a mutual dialogue, which “is a form of communication in which the participants subject themselves to the unforced force of the better argument, in order to produce a tentative consensus about problematic claims” (McCarthy, 1984 p291). So knowledge is not based on unreflective self-reports alone, but is created either through critical dialogue as a joint venture, or by using techniques of reflexion to substantiate or refute knowledge claims.

“Ultimately knowledge cannot be reduced to formal procedures because it arises from the symbolic interaction between societal subjects, who reciprocally know and recognise each other as unmistakeable individuals” (Habermas, 1987b p137)

The act of knowing is therefore grounded in a subject-subject relationship that allows them to come to a joint understanding in relation to the object, whatever that object may be (Morrow, Torres, 2002).

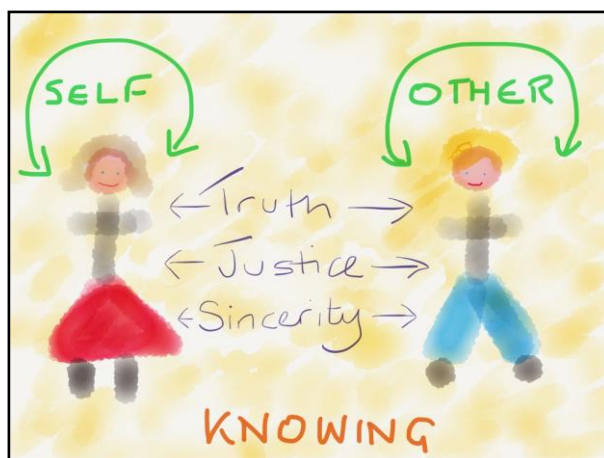


Figure 10- Existentialism: The theory of Communicative Action is embedded

Habermas regards mutual understanding as the purpose of human speech, and he argues that a rational society is arranged to achieve this end (Love, 1995). There are two main forms of social action, strategic action and communicative action (Habermas, 1984, Habermas, 1987c). Strategic action is action that is oriented towards control and success. It follows “rules of rational choice” and can be evaluated in terms of how effective it is in influencing others (Roderick, 1986). It has also been suggested that it is a way to control or manipulate others "without their agreement or consent" (Mangion, 2011 p283). The characteristics of a system where strategic action is the prevalent mode of interaction is that the other is reduced to being an object and the goal is independent of the means to achieve it. This results in there being a causal explanation of the relationship of the means to attain the goals. Communicative action is markedly different from strategic action. Communicative action (Habermas, 1984, Habermas, 1987c) is action oriented toward reaching self and mutual understanding. It has its foundations in humanistic existentialism where the act of knowing is grounded in subject-subject relations, and goals that are achieved through participation and interaction. There is therefore no separation of the means to attain the goals from the goals themselves. It requires understanding the reason for one's actions so that people in participation with others, evaluate the reasons given for the claim and judge whether they are acceptable or not.

Habermas proposes an ‘ideal speech situation’ that needs to be in place to enable communicative action (Habermas, 1984). The ideal speech situation occurs when there is a way of communicating between people that is mutually understandable. Then assuming that the participants are able to communicate and understand each other, how successful the communication is depends upon meaningful relations being established between members of society and the personal integrity of the communicators. This situation is described as one where the speaker believes that the statement they have made is true; that they are right (justified) to make that statement; and that they are sincere in their purpose. And the listener makes a judgement about the ‘fit of that statement against the three ‘worlds’ to which the speaker relates – the objective world (everything that true statements can be about); the social world (interpersonal relations); and the subjective world (the experiences of the speaker) (Habermas, 1984

p100). What is essential about the ideal speech situation is that all people involved in the dialogue need to believe and act as if it is a real possibility. Enabling a space where participants understand each other, where everyone is included and has the possibility of raising questions and expressing doubts, and where no one is forced to accept any opinion creates an environment for the ideal discussion to take place. Thus the process of communicative action requires people to be willing to participate in both action and communication, to listen, to argue, and to compromise. It is important however that this ideal is not seen as something that only belongs to a utopian society, but rather is the way for reconstructing the concept of reason (Morrow, Torres, 2002). The ideal speech situation is in contrast to Socratic dialogues, which take place via communication structures that more often than not, are distorted by power differentials.

## **Humanistic existentialism and methodology**

Using existential philosophy, Habermas' theory of communicative action and hermeneutics to underpin a research methodology is believed to be an appropriate way to develop knowledge about the topic under investigation. The existential position outlined above influences the way that research should be conducted. The methodology that is used should:-

### **Involve practical engagement rather than detached observing.**

Existentialists view people as embodied beings, where the reasoning and cognitive powers that they show are simply the visible part of a much deeper and wider engagement with the world (Han-Pile, 2009), and it is through this practical engagement with the world that people develop knowledge (Cooper, 2012). So existentialists will seek knowledge that is based on data that is obtained through participation (Macquarrie, 1972) - something that we obtain by experience rather than by abstract reasoning (Matthews, 2006). A proper investigation of life or existence therefore requires methodologies that include practical engagement.

## **Be carried out WITH people, not ON people.**

Knowledge originates in what exists in a person's consciousness and feelings as a result of the experiences and the projects they adopt in the course of their life. Existentialism is unalterably opposed to the exploitation of others (Jones, G., Cardinal & Hayward, 2003) so gaining access to and using that store of knowledge requires collaboration. Direct interaction between people enables each person involved to understand and 'feel' the other to a much greater extent than when simply observing an interaction between others. This awareness of the other person as a presence deepens "when we are in a very aware, committed, concerned, exploratory, inquiring relationship" (Heron, 1981b p30). Likewise as the validity of knowledge is determined by its value to the individual (Kneller, 1958), so collaboration is required to ensure that the outcomes have value for all people involved.

"If I just ask the practitioners about their experiences and try to understand that, I am doing so from the position of an outsider trying to understand their insider position. Why would I do this rather than inquire into the human condition I share with others or join forces with them and inquire into our shared condition? The human person is embodied, and it is only by total embodiment, in face to face relation with others similarly embodied, that you have insider access to the human condition".(Heron, 1996 p201)

## **Enable participants to make free choices.**

Existentialism focuses on the unique individual person, and the freedom and responsibility that is tied up with their ability to make informed choice (Susman, Evered, 1978). Research must therefore be flexible enough to enable people to make different choices and also to work with the choices that they make without trying to 'correct' them, coerce them or be judgemental. A choice that may be right for one person, may not be right for another, or the initial choice made by a person may be changed in the light of what is right for them at that point in time.

## **Be action orientated**

The methodology should be action oriented, with a "transformational" intent - aiming to enable people to reach their potential. Existentialism as a philosophy is a doctrine

of action (Sartre, 2007). It believes that people are autonomous agents, and as such they have the power and the will to make choices, and always striving to 'become', to develop, to change (Cooper, 1999). It is the possibility of having a choice that is both central to taking action and central to personal development (Susman, Evered, 1978). Research on people should therefore never attempt to provide a definitive answer as this would result in people being confined or constrained by a definition of the 'essence of Man'. "Man will always be more than he can know about himself" (Kneller, 1958 p37).

### **Avoid causal explanations for behaviour.**

Central to the existential position is the idea that behind every action, individual choice is based on personal interests, values and aspiration (Susman, Evered, 1978, Matthews, 2006), and it is only through the goals and values that inform activity that anything can get disclosed in the first place (Cooper, 1999). Existentialists therefore do not believe that it is possible to separate out fact and value (describing and evaluating), because everything that we experience is already full of significance and value, with the meanings of an act integrated in the person undertaking the act. Events in life are therefore made intelligible "not as causal products of earlier happenings, but as items within a whole narrative structure" (Cooper, 1999 p158). Any explanation of behaviour therefore has to be hermeneutical, not causal (Cooper, 1999).

Cohen & Crabtree (2008) offer some suggestions for evaluative criteria for qualitative research. In the description it includes the need for research to illuminate subjective meanings and understand and articulate multiple ways of seeing a phenomenon. They suggest it should also have rich substance and content, clear delineation of the research process, evidence of immersion and self-reflection, and a demonstration of the researcher's way of knowing, particularly with regard to tacit knowledge. They also acknowledge that within the family of qualitative research important differences emerge depending on the paradigm embraced by the researcher. They suggest that because of this, researchers need to provide guidance about the appropriate criteria with which to evaluate the research based on the theoretical and methodological framework used. From an existential standpoint these criteria should explicitly include

evidence of the participant as a co-creator of knowledge, and an examination of the knowledge obtained through this process to see to what extent it is influenced by unseen ideology, political influence etc with a view to identifying how these influences can be overcome and changed. Hermeneutics, which is the basis of most qualitative research, will interpret the situation, but research with an existential base must also live up to its principles of action and transformation, and seek change. Following from the difference between understanding and knowledge that was identified by Belenky et al (1997) this methodology will aim to tease out a greater understanding of the subject from a position of intimacy with it.

“Understanding involves intimacy and equality between the self and the object, whilst knowledge implies separation from the object and mastery over it” (Belenky et al., 1997 p101)

## **Humanistic existentialism and learning**

Learning is both the main aim of the study as well as an integral part of the methodology. This is learning of the participants, and the learning of the researcher. The existentialist philosophical position underpinning the study assumes certain key attributes of people, and therefore directly influences both the view of learning and the educational practices that are adopted (Grundy, 1987). Existentialism has a focus on continuously remaking oneself, so a person is always in a state of becoming, thus it could be argued that existentialism as a whole, is an educational philosophy (Feldman, 2013).

There are some underpinning principles about learning that follow on from the positioning of existentialism above. The way that humanistic existentialism views a person ensures that the principles not only influence the research methodology, but also influence the pedagogical approach. These key principles are that education should take place with people and not be something that is done to or for them (Freire, 1996); it should involve active, practical engagement with real experiences; it needs to be flexible to enable the learner to take responsibility for their learning and learn what is relevant for them; and it should be undertaken with an overall view of enabling people to reach their full potential. Although existentialism focuses on the individual, it is not an egoistic philosophy and puts as much store on the way ‘the other’, who is

also an individual, is treated. It requires relationships that recognise the uniqueness of the other (Macmurray, 1961) which within education is about the student-teacher relationship being person-centred and knowing each other for who they are, rather than simple knowing about their place in the world (Morris, 1966).

The main idea behind existentialism is an individual and personal freedom for self-determination and self-assertion (Kneller, 1958), however Morris (1966) suggests that learners often find it difficult to accept and work with the fact that they are free agents, able to both choose and take responsibility for those choices. He suggests therefore that it is the educators job, rather than simply teaching facts, to “arrange the learning situation so as to bring home the truth of these propositions to every individual” (Morris, 1966 p135), and in addition, to raise awareness of the causes of ‘unfree’ behaviour, with a view to removing them (Morrison, 2001). This emancipatory approach to education would enable the learner to fulfil his highest potential (Kneller, 1958).

The emancipatory approach is about awakening in the learner the realisation that they are personally responsible for their own lives, helping them to base their lives on the values they feel personally responsible for, and helping them to identify those things that prevent them reaching their full potential so they can act to alter them (Morris, 1966). It is recognised however that it is not always possible to remove all constraints to allow complete freedom to act, but these constraints should not prevent an individual choosing what they ought to do, or what they can do given the limitations. What is key however is being able to differentiate between what is a real constraint and what is merely an imaginary constraint (Feldman, 2013). The goal is to enable the learner to make free and conscious choices related to their own life on the basis of true knowledge (Freire, 1996). This form of education affirms learners as always being in the process of becoming, and necessitates that education is an ongoing activity (Freire, 1996)

“Existentialist educators seek more than to inculcate knowledge and virtue; they act to arouse, motivate and encourage their students towards caring, interpretative, evaluative and creative involvement in their own lives. They wish to empower students to become aware of the social forces acting to shape and determine their characters; to extend their personal freedom so that they will be able to see what is

possible, side by side with what exists, and will “choose themselves” differently than what is expected and accepted”(Aloni, 2007 p46)

Morrison (2001) identifies a number of principles for education that has a Habermasian emancipatory knowledge-constitutive interest. These include the need for collaborative and co-operative work; the need for discussion based work; the need to increase student's rights to employ talk; and the need for teachers to “act as transformative intellectuals promoting ideology critique”(Morrison, 2001 p218). There is a fundamental distinction between communicative action and manipulatively oriented strategic action, and in introducing dialogue, learning is framed as a subject-subject relationship. Learners have to reflect on their co-participation in the process of knowing (Morrow, Torres, 2002), and educators have to respect the prior knowledge of learners. Thus critical dialogue emphasises that both teachers and learners have much to learn from each other (Apple, Gandin & Hypolito, 2001). This approach is illustrated in both Freire's problem based educational process (Freire, 1996) as well as Rogers' humanistic educational approach (Rogers, 1983), and Mezirow's approach to transformative learning (Mezirow, 1981).

Mezirow (1981) used Habermas' critical theory to develop a model of learning and education. He believes that there is a difference between the education that is required for the first level of his theory – helping adults to learn how to do something or perform a task - and that required for the third level – perspective transformation. At the technical or first level, the educator works with behavioural objectives to change behaviours and introduce new ways of working. This may result in change but learning for the learners is incidental rather than deliberate. The second and third levels of social interaction and perspective transformation (Mezirow, 1981) correlate to the practical and emancipatory knowledge-constitutive interests of Habermas, and are based on critical reflectivity, with the educator attempting to ‘enlighten, empower and emancipate’ the learners (Fay, 1987). The educator's aim is to “assist adults to assume responsibility for their decision making” (Mezirow, 1981), which fits well within the existentialist viewpoint.



## Summary

Humanistic existentialism denotes a set of philosophical principles that emphasise the individual, his uniqueness and his ability to make informed choices. In exploring existentialism, I have shown how critical theory in the form of the theory of communicative action (Habermas 1984), and hermeneutics as interpretation are embedded within the existentialist way of developing knowledge and understanding of the world around them. I have also used the main features of existentialism to identify that research from an existentialist perspective should be action oriented, be carried out with people and not on them, and should involve practical engagement rather than observation. I concluded the chapter by explaining that I believe humanistic existentialism is appropriate for this study because it fits with my revised values and beliefs about learning and enables me to maintain authenticity.

The next chapter will demonstrate how the methodology for the study has been developed, ensuring that it remains true to the existentialist position of being action-oriented and participatory. It also looks at how the study was actually operationalized in practice.

# Chapter 4 – The Methodology

## Introduction

In this chapter I will discuss the development of a new methodology that explicitly builds on humanistic existential philosophical principles. I considered and rejected a range of possible alternative options, so it was felt to be most appropriate to develop a methodology specifically for this study. I had made the decision to use Critical Companionship (Titchen, 2000) as the framework for the facilitation within the study, because of its self-contained completeness, relevance, and well-developed theoretical underpinning. I therefore decided to explore the framework with a view to transferring its use to a research methodology.

Having described the development of the methodology the chapter continues by setting out how the study was operationalised and puts the study into context. The chapter concludes by describing the methods that were used in the study for learning, generating data, and analysing the data. A version of this chapter has been published (Williams, McCormack, 2017) (Appendix 9a)

## Developing the Methodology

The decision of what methodology to use for a particular study is generally based upon the question that needs to be answered, the philosophical stance that is underpinning it, and the context and culture that provide the backdrop.

Methodology is best understood as

“...the overall strategy for resolving the complete set of choices or options available to the inquirer. Far from being merely a matter of making selections among methods, methodology involves the researcher utterly - from unconscious world-view to enactment of that world-view via the inquiry process” (Guba, Lincoln, 1989 p183).

To align with my philosophical position the methodology for the research had to include actually facilitating the nurses WBL rather simply talking about it or observing

it; it had to allow me as the researcher to be fully engaged in this facilitation; it had to involve the nurses as participants in the research, and not simply subjects; it had to be flexible enough that it could adapt if necessary should circumstances change; and it should be able to deliver a practical understanding of the role of the facilitator of WBL rather than a definitive explanation. The decision to develop a methodology to specifically fit this study and include both the learning and the enquiry as integral parts came about after considering and rejecting existing action-oriented methodologies such as Participatory Action Research and Co-operative enquiry.

A Participatory Action Research approach was not felt to be appropriate because although my research was going to involve action and participation, participatory action research is about people engaging in collaborative processes “aimed at improving and understanding their worlds in order to change them” (McIntyre, 2008 p ix). In this study while we were attempting to understand something (the role of the facilitator supporting nurses to learn through their work) we were not setting out to intentionally change anything. The outcomes might include transformational change in the individual practitioners who were participating in the research, but this change would be their personal change rather than contextual or environmental change as a planned intention of the research process.

A co-operative inquiry was also considered as a potential option for a methodology, but this was rejected because of the practicalities of enabling the participants to be full co-researchers. Although the practitioners in my study were going to be participants in the research as opposed to subjects, this was not going to be a full participatory research study. Participatory research has been defined as an “action-oriented research activity in which ordinary people address common needs arising in their daily lives and in the process generate knowledge” (Park, 2006 p83). The key element of participatory research that made it unsuitable for this study would be the central role that the practitioners would have to play, potentially determining what problems to address and taking a lead or shared lead in the research process. Knowing the contextual issues in the organisation at the time, this did not seem like a feasible option.

## **Critical Companionship as a Research Methodology**

Whilst undertaking the literature review, I had located and reviewed six existing models or frameworks for facilitating a variety of learning, from critical reflection in a classroom to practice development in practice. Reviewing these frameworks led me to make the decision that I would use Critical Companionship (Titchen, 2000) as the framework to guide my facilitation in the study. It is the most complete framework, and has the greatest depth of theoretical work to support it, through the doctoral work of Titchen (2000). In addition, it is a framework that I was familiar with having worked with it during my Post Graduate Certificate in Facilitation prior to starting this research. In this next section I will show how I used creative processes to try to capture an understanding of how Critical Companionship could work as a research methodology. I started by deconstructing the Critical Companionship framework and exploring the concepts, domains and underpinning theories. Following this, and working within my identified philosophical stance, I re-visioned the concepts from Critical Companionship into concepts for facilitating a critical, participative enquiry. The original Critical Companionship concepts, and the new concepts for a critical, participative enquiry were then linked together to develop the transformative, action-oriented research methodology for this study.

### **Methodological Map**

The methodological map (fig.11) is designed to demonstrate the methodology both conceptually and visually. This map keeps the essential elements of the original critical companionship framework, provides a guiding structure for the research process and highlights the action-oriented critical intent of the research. It also makes it easier to visualise the methodology, in particular how the learning and the enquiry, although working as parallel processes, also work together as a whole. By deliberately referring to the methodology as a map rather than a framework, the intention is to emphasise the potential to move freely through the methodology using it as a guide and direction finder, rather than as a rigid constraining structure.

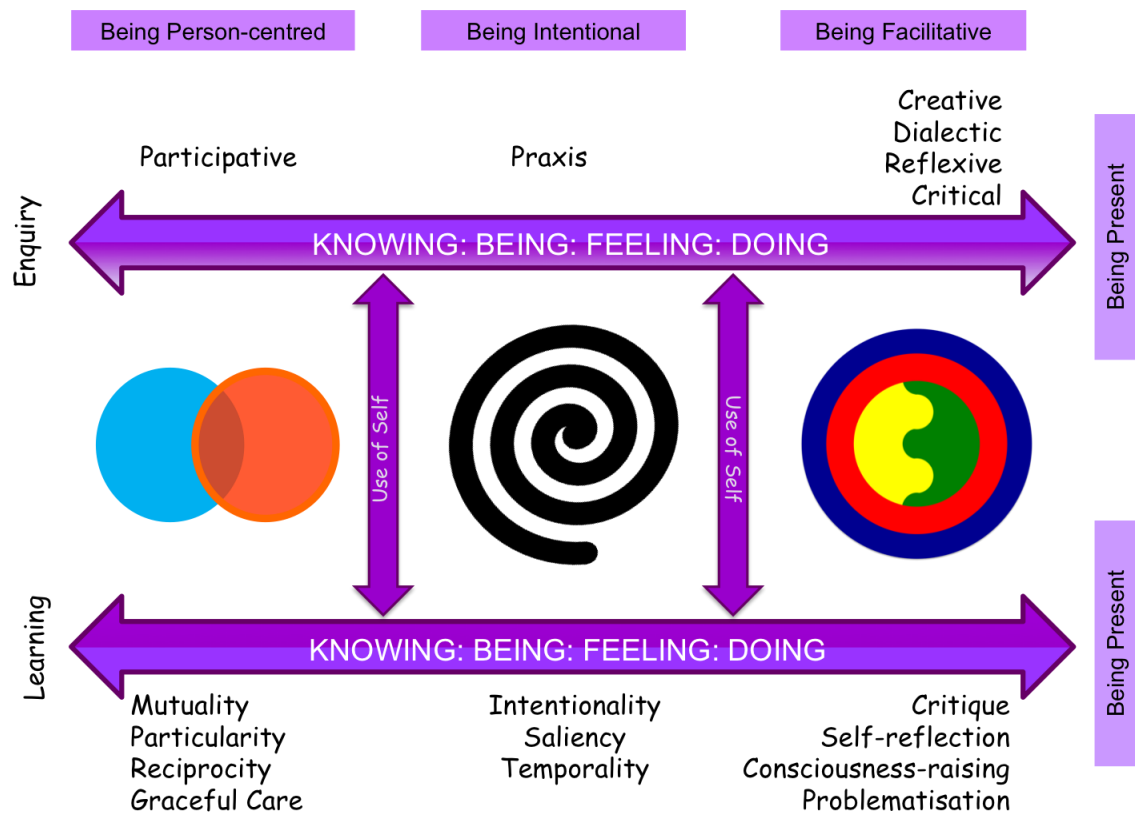
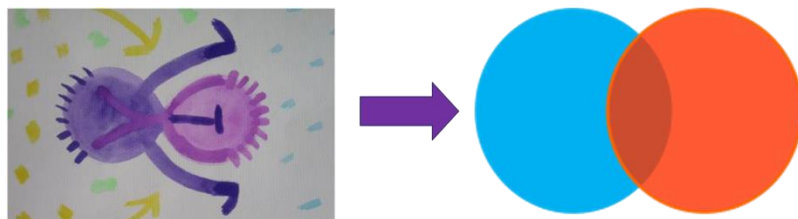


Figure 11- Critical Companionship as Methodology

The methodology consists of four domains or strands. These domains blend the domains from Critical Companionship with constructs for a critical enquiry, and the resultant research domains are:-

- Being Person-centred
- Being Intentional
- Being Facilitative
- Being Present

## Being Person-centred



*Figure 12- The Being Person-centred domain – from creative work to a diagrammatic representation for the methodological map*

The ‘Being Person-centred’ domain emphasises a carefully negotiated, non-hierarchical relationship where both parties share responsibility for learning and developing knowledge. In *Critical Companionship* (Titchen, 2000) it is developed from Campbell’s theology of professional care (Campbell, 1984) and the work of Rogers (1983) and his helping relationship in an education context. The meaning of companionship in this study is that referred to by Campbell (1984), where companionship is described as being a temporary relationship that is less than a friendship but still involves a commitment to the other person, whilst recognising that both have their own lives to lead. Campbell emphasises that it is often a chance meeting that continues all the while there is a joint purpose, but when the purpose is over the companionship ends and the individuals continue on their own journeys. He recognises that although painful, this parting is essential (Campbell, 1984).

The ‘Being Person-centred’ domain on the enquiry side sets out the relationship between the researcher and the practitioners<sup>4</sup> in the research. Within the humanistic existentialist philosophical position there is a mutual respect for individuals, recognition that people are autonomous (Cooper, 2012) and have a freedom of choice, and that this freedom is central to taking action (Susman, Evered, 1978). Person-centredness (McCormack, 2004) contains four core concepts that sit within the underlying philosophy of humanistic existentialism. They emphasise the unique nature of all the participants in the study (the researcher and the practitioners), their individual

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<sup>4</sup> The issue of how to refer to the participants in the study directly relates to the development of the methodology. Initially I was referring to the nurses as practitioners when I was discussing the facilitation and participants when discussing the enquiry, but as time has moved on I feel that this way of naming them emphasises rather than closes the gap between the learning and the enquiry side of the methodology. I have therefore made the decision that I will refer to them throughout as practitioners.

backgrounds, values and beliefs that have to be considered, and within a context that will also influence individual participation and hence the study as a whole. Being person-centred is believed to be “key to human flourishing as ends and means in development and research”(McCormack, Titchen, 2006 p256). Research that is person-centred should therefore be flexible, be done with people, rather than on them, and should share the generation of knowledge. This domain’s concept is therefore ‘participative’. **Participative** means something that is shared, and that people are involved, and the methodology requires participation from all parties in the creation of knowledge. Despite the ethos of participation it is recognised that there will still be an unequal level of involvement in some aspects of the study. These levels of involvement reflect the fact that the researcher has undertaken the initial design and planning of the research, and the topic under investigation is her topic. Decisions made once the study is underway however will take place in collaboration with the practitioners, and some of the key features in the design of the methodology are there to make participation as easy as possible for the practitioners. Therefore, although the study will be a participative inquiry, it is not a true ‘co-operative inquiry’ as described by Heron (1996).

*Table 1-Levels of participation within the study*

Aspect of the study	‘Side’ of the methodology	Researcher	Practitioner
Involvement in the experience and action being researched	Learning	Full	Full
Involvement in the decision making	Enquiry	Full	Partial

Titchen (2000) deliberately chose to use the word ‘companion’ as signifying a relationship that comes together for a specific purpose with a mutual parting when that purpose is complete, and in the methodology where the researcher becomes the Companion to the practitioners in the learning process, so the practitioners in the study become companions to the researcher in the research process. Creating this interpersonal relationship is essential to developing understanding through

“Communicative action” (Eriksen, Weigard, 2003, Morrow, Torres, 2002) . The interaction is most effective where the people interacting feel safe, respected and valued, so the relationship between all the participants is a key part of the methodology.

## Being Intentional



*Figure 13- The ‘Being Intentional’ domain – from creative work to a diagrammatic representation for the methodological map*

The three process concepts within this domain have both rational and intuitive dimensions. The domain is therefore a combination of acting intentionally and with self-awareness, but also acting on intuition (Titchen 2013 Personal Communication). In Critical Companionship (Titchen, 2000) this domain flows between the ‘Relationship’ domain and the ‘Facilitation’ domain, so that developing the relationship occurs at the same time as the facilitation.

The concept that sits within this domain on the enquiry side is **Praxis**. Praxis is an intentional process of thoughtful, mindful action, which is guided by a moral and ethical stance to act truly and justly. Existentialism is a doctrine of action (Sartre, 2007), in that rather than having some pre-existence, people are what they do. This requires a methodology that is action-oriented and transformational – aiming to enable people to reach their potential. Whereas Marx saw praxis as a form of productive activity where the individual initiated the process of knowing in a subject-object relationship, Freire defined praxis in existential terms that refer to a subject-subject relationship, and “love” rather than conflict (Freire, 1996, Morrow, Torres, 2002). Habermas also felt that the capacity of a society to adjust and grow was directly related to the communication between people themselves, and it was the people themselves who should decide what changes were needed and carry them out (Love, 1995).



In this methodology it is the interplay between understanding and action that occurs through the concept praxis, and its positioning is critical to turning the Critical Companionship conceptual framework for facilitation into a research methodology for a critical collaborative enquiry that links theory and practice. Praxis is seen as an intertwined process, depicted by the spiral of constant movement, which has both a hermeneutic element and an emancipatory element (Titchen, McCormack, 2010). The understanding develops from the facilitation domain, and this is turned back into action in the facilitation activities of the facilitator and the learning activities of the participants.

- The hermeneutic element of praxis

The hermeneutic element facilitates understanding and learning (Grundy, 1987). Understanding is developed from data that is obtained via the senses, which is then interpreted and given meaning. And because the meanings of an act are tied up in the act itself, any explanation of behaviour has to be “hermeneutical, not causal” (Cooper, 1999 p158). All understanding includes an act of interpretation, and that understanding “includes a pre-understanding, a way of looking at things and conceiving things that determines how we grasp them”(Macquarrie, 1972 p100). If knowledge is to develop and increase however, it is essential that there is a flexibility to this interpretation. This is achieved through constant interplay between the interpretative categories and the actual experiences, revising interpretations when necessary (Macquarrie, 1972).

- The emancipatory element of praxis

The emancipatory element is about engaging in reflective activity to raise awareness of the constraints that are present in individual situations, thereby enabling action to be taken overcome them (Grundy, 1987). Communication has a double structure in that speakers simultaneously say something (assert a position) and do something (assert a relationship) (Love, 1995). This mode of action becomes emancipatory when the production of knowledge through communication is taken one step further, and by a process of analysis using self-reflection and critique a determination is made as to whether the statements identify things that can't be changed, or whether in reality they are simply ideological ideas that can in practice be changed. This does not necessarily mean that the original knowledge is wrong, just that in this particular situation (Fay,

1987) it doesn't apply (Habermas, 1987a). It is the permanent changing of awareness and subsequent actions of individuals that makes these changes transformational. It is this constant intentional *movement* between understanding and action that brings about change, as transformations cannot be achieved without engaging the understandings of the practitioners involved, however understanding alone will not lead to transformation (Carr, Kemmis, 1986).

Praxis is the 'engine' of the methodology, hence its positioning at the centre of the methodology map. Habermas (1987b) describes praxis as the 'centre of human activity' and as such it is believed to be an important component for those working within a critical paradigm (Warelow, 1997). Its central positioning in the methodology means that it links both with the other domains and with the 'human' elements of the people involved in the research, and it provides the link between the two 'sides' of the study. It also draws from both the relationship domain, as the need for relationships 'of love' to support enlightenment and emancipation, and from the facilitation domain as the source of knowledge. Praxis therefore supports the critical intent of the study which is to not only develop knowledge, but also to bring about the emancipation and transformation of all those involved (Trede, Higgs, 2010). In educational terms, praxis has been described as bringing about the self-development of each individual learner (Kemmis, Smith, 2008).

### Being Facilitative

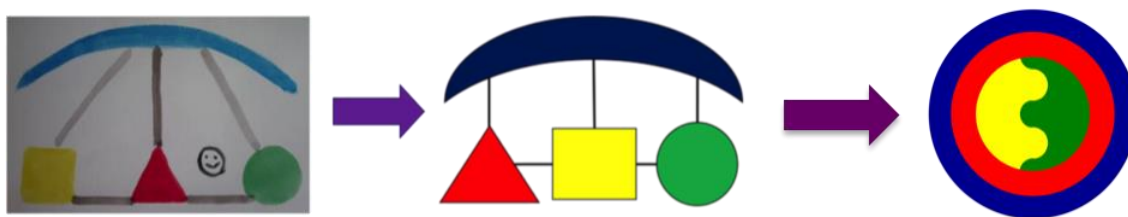
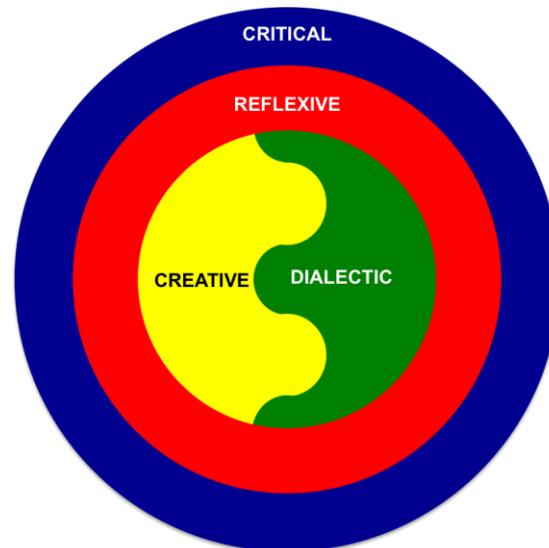


Figure 14 - Creative work of the 'Being Facilitative' domain – from creative work to a diagrammatic representation for the methodological map

In Critical Companionship the 'facilitation' domain is concerned with raising awareness, supporting critical reflection, uncovering embedded knowledge and identifying potential areas for change (Titchen, 2000). The four concepts in the domain

have been informed by critical theory (Titchen, 2000), and have an emancipatory cognitive interest (Habermas, 1987a).

The 'Being Facilitative' domain within the enquiry sets out the processes that underpin all the aspects of knowledge generation from the study. Understanding moves beyond simply describing individual interpretations to identify how any distorted understanding can be changed. This is achieved through the three elements or movements of Critical research (Alvesson, Deetz, 2000 p164).



*Figure 15- Diagrammatic representation of the four data analysis processes used in the methodology*

Interpretation starts with the individual meanings of the experiences for the participants and is captured and explored in this methodology using **creative** and **dialectic** processes. It produces insights into the issue and highlights the hidden or least obvious aspects and meanings. **Reflexivity** is used to identify the things that impact on the insights and subsequent interpretations. It looks at the problematic nature of these insights and the underlying social order that influences them. **Critical** indicates alternative ways of relating to the insights and interpretations, and raises questions on their seeming robustness by encouraging alternative ways of constructing reality

The three movements and four process described will blend with each other, being used as and when most appropriate to facilitate a deepening understanding (Fig 15).

**Creative** – The creative arts have been used throughout the development of the methodology, and they are also an integral part of the methodology. Capturing something creatively is a form of presentational knowing and it is generally believed to emerge from and be grounded in experiential knowing (Heron, Reason, 1997). The process of creating something takes time, and this time is also time for reflection (Cruickshank, 1996), which enables a greater degree of flexibility, and thereby opens up more options (Allen, 1995). The creative arts can therefore be used to represent experiential knowing in richer, expressive forms (Lliamputtong, Rumbold, 2008).

Using the creative arts within the data analysis process is based on the knowledge that creativity can support the expression of embodied knowing (Titchen, McCormack, 2010), and also enable the practitioners to better participate. In the theory of communicative action one of the key aspects is ensuring all participants are enabled to contribute and express their views freely. It has been suggested that using creativity blurs the researcher / practitioner boundaries (Lliamputtong, Rumbold, 2008), as it does not depend on traditional ways of analysing and explaining. This means that practitioners can be freed from the constraints associated with more formal processes of analysis (Simons, McCormack, 2007). When using the creative arts as a form of presentational knowing, verbalisation by the creator is important to clarify meaning and mutual understanding (Cruickshank, 1996). (See methods section below).

**Dialectic** – The main purpose of dialectic thinking is to create overarching frameworks that illustrate how an idea can be consistent, even though it is formed from different ideas, and it also enables implicit assumptions to be identified, and different insights to be gained (Starbuck, 2006). Dialectic thought thus emphasises a “both/and” position rather than an “either/or” and this synthesis of ideas means that there is not a one-way cause and effect relationship between the parts, but rather a process where one factor may have an effect on another, but it is just as likely that the latter will have a simultaneous effect on the former (Harden, 1996 p34). Everything is in a process of motion, development and change, where phenomena are understood in relation to other phenomena, and the world is recognised as a process of relationships or interdependencies where facts and values are intertwined. (Harden, 1996). Starbuck (2006) suggests that it is dialectic thinking that enables humans to see the ambiguities and subtleties in everyday life that they would ordinarily ignore. To enable this, it is

important that the issues are kept as wide open as possible, and that instances that indicate variation rather than consensus are identified. This will mean reinforcing ‘weak, hidden, obscured and peripheral voices and discourses’ (Alvesson, Deetz, 2000 p152). The use of alternative values and understandings that effectively contrast the taken for granted ones, may encourage re-thinking (Alvesson, Skoldberg, 2009). Starbuck warns against trying to do this too quickly and simply, as he believes that the contrasts themselves can challenge thinking and understanding; raise awareness of the complexities of the situation; discourage overgeneralisation and foster appreciation of individuality and variety (Starbuck 2006 p149). Collaborative research can stimulate and support this dialectic thinking, as the collaborators can assist the researcher to clarify concepts (Starbuck 2006). Dialectic thinking is one of the principles guiding critical enquiry put forward by Freire, where parts are understood in relation to wholes, and understanding is developed through open discussion (Freire, 1974). The best analogy for the suggestion to move between parts and whole is suggested by Cooper, who likened events in a person’s life to a novel, where they are made understandable “not as causal products of earlier happenings, but as items within a whole narrative structure” (Cooper, 1999 p158).

In this study dialectic discussion will be facilitated with a group of practitioners and will involve them comparing and contrasting their own experience with that of others and seeing how others have interpreted their experience (Shaw, 1999). Dialectic thinking will also be undertaken by the researcher when undertaking further analysis of data. Both processes will be supported by the use of creativity. The whole dialectic process will therefore move backwards and forwards between individual practitioners, their individual experiences and the group experiences; and between raw data and developing themes, using one to inform the other. It is hoped that examining the tensions, contradictions and complexities of the situation, will enable shared, deeper understandings (see methods section below).

**Reflexive** - Reflexivity is a fluid process that is based on the idea of “transforming personal experience into public and accountable knowledge” (Finlay, 2002 p533). The researcher, the method and the data are interdependent and connected (Mauthner, Doucet, 2003), and it is the role of reflexivity to highlight and explore that connectivity by engaging in explicit, self-aware analysis throughout the research process (Finlay,

2002). Reflexivity is therefore the ability to treat oneself as the object of inquiry within the world (Schön 1987), however judicious use of ourselves in our research needs to be essential to the argument and not just a decorative flourish (Etherington, 2004a) or over-indulgent introspection ie. “Extravagant grubbing about in the soul” (Heidegger, 1953). Reflexivity requires a more immediate, dynamic and continuing self-awareness than reflection (Finlay, Gough, 2003), and involves questioning and exploring one’s own assumptions and understandings (Freshwater, Rolfe, 2001). It has been described as an “ongoing conversation about experience whilst simultaneously living in the moment” (Hertz, 1997). Reflexivity also requires being aware of how one’s hierarchical position and personal history may impact on the enquiry process (McCabe, Holmes, 2009) and the cultural circumstances that provide the backdrop to the study as well as impregnate all the interpretations (Alvesson, Skoldberg, 2009). It therefore acknowledges that the construction of knowledge and power is an inherently social process (Riach, 2009). Reflexivity is different from reflection in that it “problematizes those things that reflection takes for granted” (Taylor, White, 2000 p198), and includes being reflexive about the things that were not done as well as those that were. It has also been suggested that there is a limit to how reflexive it is possible to be, as some influences may only become apparent some time after finishing the research (Mauthner, Doucet, 2003)

Reflexivity in the study will be approached from three angles.

An **introspective** reflexive approach examining the impact of the researcher

- On the research
- On the facilitation

This approach is designed to make the embodied, situated and subjective researcher visible within the study by examining how their self-location, position and interests influence all stages of the research process (Pillow, 2010), and the importance of the researcher becoming consciously aware of these factors and thinking through the implications of these factors for his/her research (Pillow, 2010).

This approach will also examine how the researcher’s knowledge, skills, values and beliefs have been influential on their use of the Critical Companionship facilitation

framework, during the process of fieldwork. The insights gained from this will be used to develop the researcher's facilitation skills through inbuilt feedback loops.

A **relational** reflexive approach examining the impact of the relationship between

- The researcher & participant
- The Critical Companion & practitioner

This approach will, in conjunction with the participants/practitioners, consider the relationship between the researcher and the participants/practitioners and how this impacted on both the facilitation and the research. It will aim to identify and address power relations between researcher and participant (Etherington, 2004b), and explore the contextual conditions and constraints under which these relationships operated (Mauthner, Doucet, 2003)

An **epistemic** reflexive approach questioning the interpretation of data

The aim of this approach will be to subject knowledge claims to critical analysis by making visible how they were made (Taylor, White, 2000). How knowledge is acquired, organised and interpreted is relevant to what the claims are (Pillow, 2010), so this approach will identify and acknowledge the part the researcher plays in both interpreting the many 'voices' in the research, as well as making the decisions as to which extracts are presented as evidence (Mauthner, Doucet, 2003). The aim is to "produce research that questions its own interpretations and is reflexive about its own knowledge production, towards the goal of producing better, less distorted research accounts (Hertz, 1997).

These three approaches to reflexivity aim to increase the understanding that is developed from the study by making explicit the judgements, biases, assumptions and concerns on which interpretations have been made (Mauthner, Doucet, 2003); to enhance the trustworthiness of the study by being open and transparent; and to increase the learning that occurs within the study by creating 'feedback loops' to ensure insights gained are used to influence further practice.

Table 2- Reflexivity focussed throughout the study

	Focus of the reflexivity		
	Introspective	Epistemic	Relational
Learning	The impact of ME on the facilitation	The interpretation of the data	The Critical Companion / Practitioner relationship
Enquiry	The impact of ME on the research		The Researcher / Participant relationship

**Critical** – The critical movement of the ‘Being facilitative’ domain works with the data that has resulted from the interpretive and reflexive movements above. The critical element aims to identify how and why the existing context constrains, influences and frustrates both the action and the interpretation of the participants, and suggests how to correct them (Carr, Kemmis, 1986)

These four processes are blended together and woven through different data collection and analysis methods so as to ensure coherence both with the philosophical stance and within the methodology. The actual methods used for data collection and analysis are discussed in the methods section below

## Being Present

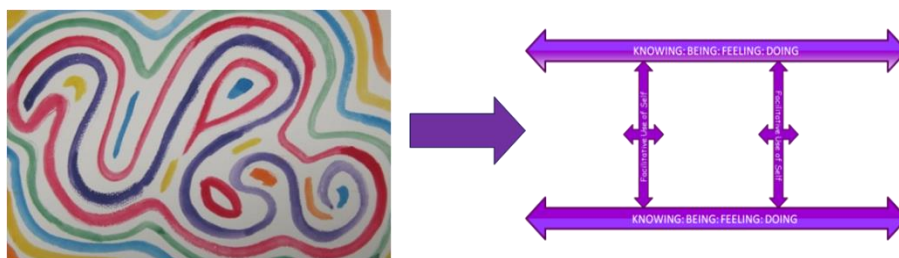


Figure 16- The ‘Being Present’ domain – from creative work to a diagrammatic representation for the methodological map

The Facilitative Use of Self domain is a complex, dynamic and overarching domain. It involves being able to use the other domains in the best mix to support the learning of the practitioner and includes within it the human aspects that represent the critical companion as a person (Titchen, 2000).



The 'Being Present' domain is threaded throughout the methodology in the same way as the Facilitative Use of Self domain is in the Critical Companionship facilitation framework. Within the methodology it is made up of three components. There are two parallel arms that have a function both as a visual metaphor as well as a process. Working as a visual metaphor the arms demonstrate the way the learning and enquiry processes within the methodology run parallel to each other. Existentialism holds that as living is participatory and involved - an embodied engagement (Cooper, 1999) - any enquiry needs to acknowledge the importance of participation in the act of knowing (Macquarrie, 1972). An appropriate investigation can therefore only take place from an embedded position (Panza, Gale, 2008). The methodology therefore needs to have the researcher and the participants both embedded in the process that is being investigated, as well as collaborating in the enquiry. Whilst the Being Person-centred domain is focussed on the relationship between the participants and the researcher, and the collaborative nature of the enquiry, it is the embedded nature of both the researcher and the participants that is highlighted in this domain. Each arm also deliberately has two colours in it to represent two people in both parts of the study. The horizontal arms contain the 'human' aspects 'doing, feeling, knowing and being. These consider being aware of 'being in' and 'being with' the research, being authentic and embodying the process (McCormack, 2003). These arms therefore represent not only my presence as a person in both the learning work and the enquiry work with the practitioners, but also the presence of the practitioners as people embedded in the learning and the enquiry.

The third part passes vertically between the domains in the methodological map, providing a link between them all. It also provides the link between the two parallel 'human' aspects and therefore the two sides of the study. These represent the presence of the researcher as the facilitator of the whole study, holding all the parts together, and through the use of professional artistry (Titchen, Higgs, 2001) "being able to see the whole and the parts and moving between them and getting the balance, form and structure right" (Titchen, Manley, 2006 p342).

## Operationalising the Study

The study was based around an action cycle. Within each action cycle five practitioners worked individually with me as their Critical Companion. As part of the Critical Companionship relationship to facilitate their learning they were working with me as individuals, but in the enquiry process they were one of a group of participants. As a group they met together every 3 months to analyse their experiences. In the diagram below, which represents one action cycle, the outer purple circle with the internal arrows represents me as the facilitator / researcher acting as critical companion to five individual practitioners, facilitating the research, and ‘holding’ the study (‘Being Present’ domain). Within each action cycle there are 3 different praxis spirals occurring.

Praxis cycle 1 – The practitioners understanding, learning and developing their own practice. In the diagram above the five ‘arms’ inside the circle are the five individual practitioners who come into the research both as individuals and as professional nurses, developing themselves and their practice individually through their own praxis spirals.

Praxis cycle 2 – Me as the facilitator understanding and developing my own practice as a facilitator. The central black spiral in the diagram above represents my praxis spiral as I explore my facilitation skills to come to a greater understanding, and to transform my practice to make me more effective.

Praxis cycle 3 - All of us as a group understanding and developing knowledge about the facilitation of learning through work. The multi-coloured central spiral in the diagram above represents the coming together of all research participants (the practitioners and me) to develop a deeper understanding of the constraints and the positive mechanisms and processes necessary for the facilitation of learning through work. This group met four times through the course of the study (see Creative Reflective Analysis in the methods section below).

The facilitator – The outer circle with the 5 arms into the inside of the circle represents me as the facilitator holding the study together and working individually with each of the practitioners.

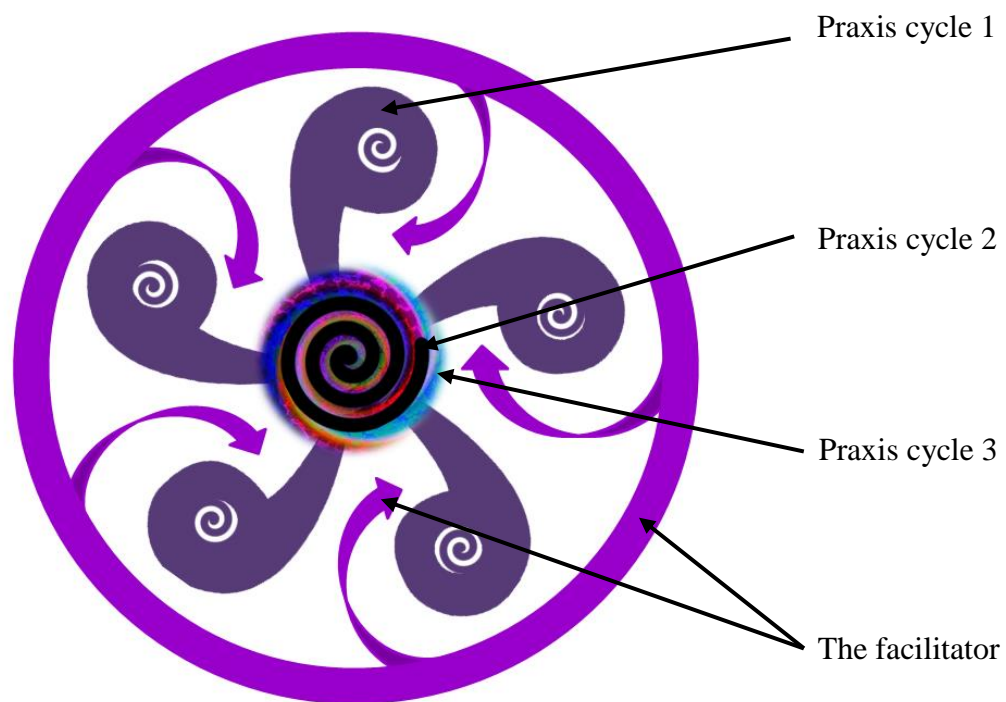


Figure 17- Diagrammatic representation of one action cycle

The study took place through two main action cycles. Each action cycle lasted for 1 year. Action cycle 1 went from January 2012-January 2013, and then after a three month period for data analysis and recruitment, Action cycle 2 went from May 2013 – May 2014.

Table 3- A Gantt chart showing planned research process

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2012	ACTION CYCLE 1: Field work year 1											
2013		Data analysis				ACTION CYCLE 2: Field work year 2						
2014	Field work year 2				Data analysis				Overarching analysis			



The micro design of the study was much less easy to plan. Every one-to-one meeting, and each data analysis workshop had the potential to change the ways of working. They are captured here where the overall picture is of a tree, but on closer inspection the tree is made up of multiple small spirals. The study as a whole therefore has an emergent design.

*Figure 18- The micro design of the study*

## **Research site**

The University Health Board in which the study took place provides Acute, Primary, Community, Mental Health and Learning Disabilities services to a population of around 370,000 in an area of Wales. It covers 5,781Km<sup>2</sup> which is almost 25% of Wales' landmass but has only 13% of the total population of Wales. Road infrastructure is poor, with travelling times being approximately 1.5hrs to travel 50 miles. Within the Health Board there are 4 General Hospitals, 8 Community Hospitals, 11 Health Centres and 55 GP practices. Approximately 3,100 Registered Nurses are employed by the organisation. At the time of the study the Health Board was arranged around a County Structure, with each County having a Head of Nursing, and each acute hospital having a Nurse Manager. The hospital services were further divided into scheduled and unscheduled care services with respective clinical nurse managers. The community nursing services were also managed in Counties with Nurse Managers who report to the County Head of Nursing. The Counties were then further divided into areas, with each area having a Team Leader. In addition to this structure there was also a corporate nursing structure, which included the Director of Nursing, two Associate Directors of Nursing, and other teams that work across the Health Board eg. Practice Development, Infection Control, Medicines management etc.

## **Ethical Issues**

The ethical and design issues that were given due consideration within the study are summarised below.

### **Informed consent**

Ensuring voluntary participation and informed consent for all activities was a key ethical consideration. Potential participants were given an information sheet that explained the study (Appendix 2A). They were then required to initiate contact with me to express an interest in participating and discuss the study further. The participants were required to sign a consent form (Appendix 2B). Agreement for the practitioner to participate was obtained from their line manager/team leader and the senior nurse manager for that area.

### **Process Consent**

Due to the dynamic nature of the study consent for various situations was obtained as and when the situations occur eg: A contract for ways of working was drawn up between me and each practitioner as we set up our Critical Companionship relationship. In addition, the impact of the research on the contracts was worked out as the relationships were set up. In a similar way the terms of engagement for the data analysis meetings were decided and agreed by the members of the group at the time. In addition to these process issues there was always the possibility that unexpected ethical dilemmas would arise as the research developed, and I was mindful of the need to recognise and address these as and when they occurred. This required honesty, openness and integrity from all the participants, being guided by a respect for everyone's dignity, rights, safety and wellbeing. As Registered Nurses the participants are all bound by the NMC Code of standards, performance and ethics (Nursing and Midwifery Council., 2008a, Nursing and Midwifery Council, 2018). The underlying philosophy of the research is to embody democratic principles, so once the study was underway participants were collaborating in the decisions made regarding the future direction of the research.

## **Anonymity and confidentiality**

The methods used in this study were by their nature interactive, making total anonymity difficult. Considerable attention was given to agreeing terms of engagement and the principles of confidentiality throughout the study. Participants were made aware that although attention would be given to anonymity in reporting and to the appropriate use of anonymised direct quotes, due to the small number of participants in the study it was possible that people closely associated with the participants or the study may recognise individual contributions. Assurances were given to participants that they would be able to view and specifically consent to any data that was planned to be used verbatim to illustrate findings within the final report. This was also explained in the participant information sheet (Appendix 2A).

## **Practice Issues**

There was the potential during the one-to-one facilitation work for poor or dangerous practice to be disclosed. If this should occur it was planned that the researcher would be required to support the practitioner to discuss this with their line manager, in order for appropriate action/feedback to be taken. The researcher was also prepared to liaise with the line manager directly if the practitioner had felt unable to do this. The limits on confidentiality in such situations were clearly explained in the participant information sheet (Appendix 2A).

There was no direct involvement of patients in the study. However, as part of the one-to-one facilitation work the researcher might have been asked to work with the practitioner in practice observing and giving feedback on some aspect of their practice. In these instances, it was agreed that it would be the responsibility of the practitioner to ask for consent from the patient in the same way that they would for any clinical teaching. The researcher is an expert, currently practicing, clinical nurse and is bound by the NMC Code of standards, performance and ethics (Nursing and Midwifery Council., 2008a & 2015). When working in the clinical area the needs of the patient would take precedence over the research.

## **Sponsorship & Intellectual Property**

The University of Ulster sponsored the study initially and this was transferred to Queen Margaret University in March 2014. The University also provided indemnity insurance, as agreed with the University Health Board.

Intellectual property rights were assigned initially to the University of Ulster and transferred to Queen Margaret University in March 2014.

## **Funding**

The study received no external funding. A grant of £10,000 was received from the Research & Development budget to backfill some of the researcher's clinical time during the first year of field-work. No additional funding has been received.

## **Ethical Approvals**

- The University of Ulster Filter Committee - June 2011 (11/0286). The Filter Committee approved the study with no amendments required.
- The local Research Ethics Committee - August 2011 (11/WA/0209). The proposal received formal approval with no amendments required (Appendix 3A). Annual reports of the progress of the study were presented to the committee.
- The University Health Board R&D Committee - September 2011 (HD/11/020). Permission was granted for the study to go ahead in the Health Board (Appendix 3B).

## **Recruitment of participants**

The participants in the study were Registered Nurses. Inclusion criteria were that they must be currently working in the Health Board, they must want to participate, and must not be currently undertaking an academic course. Agreement for a specified amount of protected time for the practitioners was obtained from the Director of Nursing and

the County Heads of Nursing. In addition, the practitioners were required to have agreement from their line manager, as support from a manager has been identified as an important enabling feature of work-based learning (Moore, 2010). An information leaflet was prepared specifically for line-managers, and I offered to go and meet with the practitioner and their line manager to explain the study further if they wished.

There was a maximum of 5 participants in the study at any one time, and they remained in the study for one year. The practitioners for the first cohort were recruited between September and November 2011. The practitioners in the study had to feel that they could 'get on' with me before they agreed to participate. They made those decisions quite quickly, and in the most part they were based on their experiences of participating in an unrelated workshop that I facilitated. The second cohort was recruited either via personal recommendation from participants in the first cohort or were recommended to participate by their line-managers who had heard me talk about the experiences from the first cohort. Recruiting participants for the second cohort was quicker and easier than recruiting for the first and took place in April/May 2013. Damianakis and Woodford (2012) caution that when using 'snowball' techniques for recruitment and when recruiting from small connected communities additional consideration is given to maximising geographical diversity which they believe might help to minimise the risks of breaching confidentiality.

The nature of the research methodology required the researcher as facilitator to develop a negotiated, non-hierarchical, reciprocal relationship with the participants. Although at the time of setting up the research I still practised as an Emergency Nurse Practitioner, it was 10 years since I had any line management responsibility. This, coupled with the widespread geographical area of the Health Board and the number of potential participants, made it very unlikely that I would have had any prior professional relationship with any of the research participants that could interfere with that. In the event one of the participants in cohort 2 had been a fellow staff nurse in the Accident & Emergency Department about fifteen years previously.



## Introducing the Practitioners

In view of the small number of participants, and in keeping with the ethical approval the practitioners all selected their own pseudonym. Their study ID letter was also changed.

- A. **Annie** was a Clinical Nurse Specialist. She worked part-time
- B. **Bethan** was a Sister/team leader. She worked full-time.
- C. **Catrin** was a Junior Sister when she joined the study but was soon after promoted to Sister/team leader. She worked full-time
- D. **Diane** was a Staff Nurse. She worked full-time.
- E. **Emma** was a Clinical Nurse Specialist. She worked part-time.
- F. **Eve** was a part-time Staff Nurse and a Clinical Nurse Specialist. She worked full time.
- G. **Gwen** was a Staff Nurse. She worked full time.
- H. **Helen** was a Staff Nurse. She worked full-time.
- J. **Jade** was a Staff Nurse. She worked full-time
- K. **Melanie** was a Clinical Nurse Specialist. She worked part-time.

Two of the practitioners (one from each cohort) dropped out of the study after about 5 months, one due to long-term sick and the other due to family problems.

## The One-to-One Meetings

Arranging each one-to-one meeting was down to the practitioners, although I did also drive this, contacting them if I had not heard from them in a while. This was most apparent with the first cohort where I was very keen for us to meet regularly, whereas with the second cohort I was more relaxed. In the first cohort the practitioners had between 9 and 20 meetings (median 14). The next meeting was arranged at the end of the previous meeting. The meetings lasted between 1 and 1.5 hrs. The longest meeting was 2hrs. The shortest was 15mins prior to a night shift.

In the second cohort the practitioners had between 6 and 8 meetings. When we started working together we arranged meetings the same way as Cohort 1, however this changed after the second meeting and we ended up meeting when the practitioners wanted to meet up, although I did contact them if I hadn't heard from them in a while. When we did meet the meetings were again 1 to 1.5hrs long. The longest gap between meetings was 15 weeks when a practitioner was off sick. The shortest gap was a week, when a practitioner was in the middle of a difficult situation.

Not all the practitioners could attend every data analysis day for their cohort because of work or family commitments that couldn't be changed. In every day there were at least 4 of the cohort of 5 present (or 3 of 4 after the drop-outs mentioned below) (Appendix 4A)

## **Facilitation Methods**

The methods to support the learning of the practitioners within the 'Being Facilitative' domain were taken from the learning side of the methodology where they are set out as strategies within the facilitation domain of Critical Companionship (Titchen, 2000). The facilitation processes of consciousness-raising, problematisation, self-reflection and critique were used in the facilitation methods to support the practitioner's learning. The exact mix of facilitation methods and facilitation processes that were used were tailored for the individual practitioner and the situation and depended on the participant's individual development plan. This relates to the 'Being Intentional' domain, and the critical companionship processes of intentionality, saliency, and temporality. The overarching domain of 'Being Present' was also used as the practitioners and I took ourselves into the process.

Because my clinical expertise was not in the same area as the practitioners, I did not work with them in clinical practice, although the option for me to observe them was written into the study and had ethical approval. The facilitation methods therefore occurred in the one-to-one meetings, although they were also used in phone calls and emails to the participants.

**Critical dialogue.**

In our one-to-one meetings the practitioners and I spent the majority of our time in critical dialogue. This could have been discussing an aspect of the practitioner's practice, or it could have been about a project or piece of work they had ongoing. Occasionally I sent the practitioner something relevant to their learning needs and we discussed that, or we discussed political / organisational issues that impacted on their practice.

**High challenge / high support.**

Throughout my time of working with the practitioners I aimed to provide a high level of support for them, and to make this as overt as possible. I achieved this by responding as soon as possible to their requests for meetings, listening and paying attention to them, empathising where appropriate and responding rapidly in a crisis situation. I also made sure that I took account of their home life and did not allow them to become overburdened with work. Once I believed that the practitioners felt supported, I then started to apply some challenge to our critical dialogue. I did this by asking the "stupid" question to make them articulate their knowledge, playing 'devil's advocate to make them think deeper, and generally trying to gently push them outside their comfort zone.

**Observing, listening and questioning.**

Although as a rule I did not observe the practitioners in practice, I did have the opportunity to observe some of them answering phone calls or responding to other staff and I used these opportunities to offer them feedback. The most frequently used strategy was that of listening and questioning, where I listened to the practitioners talk about their practice and then asked them questions that would help them to unpick that practice and think about it differently.

**Role-modelling.**

Throughout my time with the practitioners I was aware that I was role modelling both facilitation skills as well as other professional attributes. At times I simply did this and at other times I deliberately drew the practitioner's attention to what I was doing. This was particularly if I thought the skills could be useful to the practitioner.

### **Articulation of craft knowledge.**

As already mentioned my clinical expertise was not in the same area as those practitioners who were my participants, so I generally did not offer specialised craft knowledge to them, however I did draw on my expertise as an experienced nurse, from my previous experience as a manager, and my current expertise as a facilitator and practice developer. It was a fine balancing act to prevent this flipping over into endless ‘advice giving’. There were also times where I asked questions simply to enable a practitioner to articulate things they had done well, so that they were forced to recognise their own craft knowledge.

### **Creative expression**

Creative expression was not in the original doctoral thesis that developed Critical Companionship (Titchen, 2000) however Titchen has since added it to the framework. Using the creative arts to help uncover embodied knowledge is not a commonplace practice in this setting, so I have been very cautious in its use, and initially confined its use to the group data analysis days. I did occasionally use it with the participants in the 1:1 sessions, although because of time and environment constraints this was confined to the use of Evoke photo cards.

## **Data Collection Methods**

The data collection methods are derived from the enquiry side of the methodology, and include the ‘Being person-centred’ domain, the ‘Being Intentional’ domain and the ‘Being Facilitative’ domain. The four processes of creative, dialectic, reflexive, and critical were used in various combinations to ensure that relevant data was collected. Rather than simply recording the critical dialogue, I also reflected and engaged in self-dialogue to identify ‘good’ facilitation examples. The treatment of the critical dialogue recordings was influenced by the ‘being person-centred’ domain to ensure that the practitioners remained as people within the data. The reflective process reviews were about engaging the practitioners with the four processes from the facilitation domain to support their ability to evaluate the facilitation. All the data that I collected and

worked with I was able to use through the ‘being intentional’ domain and the process of praxis to develop my knowledge, understanding and potential for taking action.

The methods used for collecting data include:-

### **Critical dialogue**

The critical dialogue between the practitioner and me in our one-to-one meetings was all digitally audio-recorded. After the meeting I made a brief record of what took place during the session and the issues that we had discussed. I returned these records to the practitioners soon after each meeting. I listened to the recording again and identified examples of particularly ‘good’ facilitation techniques or things that the participant had identified during the process review. I then annotated my notes with times from the recording to make it easier for me to find them again should I need them to illustrate the findings. The data that were collected by this method were used to illustrate points that a practitioner made in the data analysis workshop, so in general they were not transcribed.

### **Reflective process reviews**

At the end of each one-to-one meeting the practitioner undertook a short verbal reflective review of the session. I asked the practitioner 4 questions which sometimes were answered quite quickly and sometimes lead into a further discussion:-

- Did we do anything particularly helpful during the session?
- Did we do anything particularly unhelpful during the session?
- Did I pick up and act on what was important to you?
- Was the balance of challenge and support appropriate? This question included making a mark on a challenge and support grid (Appendix 4C)

The initial plan was to undertake this process review at the start of the following 1:1 session, but the practitioners were finding this very difficult, so this was changed in February 2012 so the process review occurred immediately after the 1:1 session. I transcribed the process reviews and returned them to the practitioners about a week before the data analysis workshop. The practitioners were then able to use these to help with their reflections prior to attending. The smaller number of process reviews in

relation to the number of 1:1 sessions is partly because the data collection method was changed in February 2012 (see above). It was also because there were a few times when it would have been inappropriate to collect the review, either because the practitioner was distressed, or because they had to return to the clinical area (see process consent in ethical issues above). The data that were collected by this method also provided a valuable feedback loop for me.

### **Researcher field notes**

As soon as possible after the one-to-one meetings I made reflective notes about the meeting that were both written and occasionally used the creative arts. The focus of the notes was my thoughts, feelings and initial impressions of the facilitation session, and any questions that the session raised for me. The field notes were arranged to capture my doing, feeling, being and knowing as set out in the 'being present' domain of the methodology (Appendix 4B). Writing the field notes proved challenging, both in terms of time as well as finding something different to say or comment on after so many one-to-one meetings. This was particularly noticeable when I saw two participants 'back to back'. Eventually I stopped trying to 'force' my writing, and would sometimes just record sentences, and sometimes would create something visual.

### **Participant's own records**

At the start of their period of time in the study the practitioners were given information about collecting evidence for portfolios. They all undertook a critically reflective self-assessment against the attributes from the REACH framework and from this we worked together to draw up a learning plan for them. Throughout their time in the study the practitioners were encouraged to collect evidence for their portfolios and initially were enthusiastic to do this, and even suggested that they keep similar reflective records of each session as I was doing. However the reality was that this proved too difficult, and instead I sent them my record of the 1:1 session. To try to make things easier for them the format of the 1:1 record was changed so that there was room for the practitioners to record their achievements against the agreed plan of work. In the event no records from the participants were used as data.

## **Data Analysis Methods**

The analysis of the data was facilitated using both sides of the methodology. The domains on the learning side of the methodology were used to facilitate the practitioners' participation in the data analysis via the Creative Reflective Analysis workshop. The enquiry side of the methodology, and particularly the four processes from the 'being facilitative' domain (creative, dialectic, reflexive, critical), was used to undertake both the data analysis methods. The audit trail of the data analysis process can be found in Appendix 6.

### **Creative Reflective Analysis**

Creative Reflective Analysis describes a participative method of analysis that is facilitated with the group of practitioners. This method of participatory data analysis is similar to Creative Hermeneutic Analysis (Boomer, McCormack, 2010, Van Lieshout, Cardiff, 2011). The key difference in these two methods is that in the hermeneutic analysis the participants undertake their creative work based on their intuitive grasp of all the material that they looked at, and then as a group start to theme the data based on their shared understandings. In the reflective analysis that was used here the participants use creative methods to access their embodied knowledge, and then critical discussion with other practitioners to compare and contrast their experiences. Developing an understanding through communication depends on "free discussions based on goodwill, argumentation and dialogue" (Alvesson, Deetz, 2000 p90), and that is what we were aiming to achieve. The Creative Reflective Analysis workshops were the first part in the data analysis process where the practitioners participated by analysing their own experiences. All the data analysis that followed used the data that was initially generated by the practitioners' analysis of their experiences.

The Creative Reflective Analysis (CRA) workshop took place every four months during the participants' time in the study. In each year of field work there were therefore 3 of these 'data analysis workshops' - at the end of 4 months, 8 months and 12 months. For the CRA workshops the practitioners needed to develop ways of working together which enabled "authentic collaboration" (Reason, 1999 p212), where

no one person dominated the group, and no one was left out. The actual details of this were worked out by the practitioners as “terms of engagement”, and I facilitated this process being informed by the principles of person-centredness. In addition to analysing the data, these days also provided another feedback loop for my facilitation skills.

### **The workshop**

The workshop was run as a form of focus group and each one lasted for a whole day (approx 6hrs). The discussions during the day were digitally audio-recorded. The environment was made conducive to creative and collaborative work by having soft chairs, music and plentiful access to refreshments. Surfaces were protected and a wide variety of materials were provided for the creative work. To enhance the feeling of collaboration all the participants took their lunch together.

### **Preparation prior to the workshop**

Data Preparation - The data for these days were the notes that were made after each 1:1 facilitation session with each practitioner, as well as the transcribed process reviews that occurred at the end of the 1:1 sessions. The record of each one-to-one meeting had been sent to the individually practitioner already. I had intended to send each practitioner the data from everyone in the group prior to the workshop so that we could undertake a creative hermeneutic analysis. In the initial discussions at the start of their time in the research however, the practitioners were not comfortable with this. This resulted in the data analysis method being changed from a creative hermeneutic analysis to a creative reflective analysis.

Participant preparation - The practitioners were asked to re-read all their notes and were encouraged to reflect on the notes and their experience before the workshop. The practitioners could undertake this pre-workshop reflection in whichever way they preferred, either in writing or by just thinking. To assist with that I sent them the process reviews from their individual one-to-one sessions about a week prior to the workshop. The practitioners brought a variety of things with them to the workshops. Some came with their learning contracts and their portfolios while some came with nothing except themselves.



Researcher preparation – As the researcher I prepared for the workshop by reviewing all the one-to-one meeting records, the process reviews and my own reflective field notes. From this I identified issues that I wanted to raise with the group.

### **Activities in the workshop**

The initial activities in the workshop revolved around creating a safe space. We did some icebreakers, reviewed the ‘ways of working’, and generally caught up with each other’s news. Once the atmosphere felt comfortable I moved into the focus of the day.

Creative work - I invited the practitioners to start by reflecting on the Critical Companionship relationship; what happened in the sessions; what they took out of the sessions and back to practice; and how they made it work in practice. They then began to create an image of how they were experiencing facilitated WBL and what were the key issues emerging from their sessions. The practitioners were encouraged to create something that came from inside them and involved their thoughts and feelings rather than simply ‘facts’ and ‘things’. They were also reassured that this was not an art competition and there were no ‘right’ or ‘wrong’ answers. The researcher also created an image.

Once everyone had completed their images, the practitioners shared their work. In discussing their creative work they were encouraged to draw on their individual experiences, so they were in control of offering what was coming out of it for them. By doing this they were consciously or subconsciously analysing their journey so far. The researcher also shared her creative work and her experiences of facilitating the 1:1 sessions.

Identifying issues - From sharing the creative work a set of issues arose. These issues might be new data, or they might be further identification of issues that have arisen before.

Exploring uncovered issues - The issues arising that arose from the creative work were combined / compared with the issues that had arisen from my preparatory work. The issues were unpicked and explored using critical dialogue. During this exploration the practitioners were encouraged to use their own experiences to illustrate what they were saying, and to link these to other practitioners’ experiences, either as an example of a contrasting experience or an example of a similar experience. During this process of

critical dialogue the practitioners were encouraged to constructively critique those contextual issues that were perceived to be hindering their progress, and to identify possible ways to address them.

Relating to research questions - The three research questions were then introduced to try to identify the connection between them and the issues discussed. The practitioners were asked the questions individually but were also encouraged to question each other so that discussion ensued.

- “What goes on in your practice that helps or hinders your learning”
- “Is there anything that we have done in these sessions that has helped or hindered?”
- “Do you think you have achieved anything in this period?”
  - Personal achievements
  - Achievements that have directly impacted on your patients
  - Achievements that will directly benefit the organisation

All the discussions that took place in the day were audio recorded and transcribed. The line numbers of the transcriptions were numbered consecutively from workshop 1 to workshop 6. (See Appendix 5B for examples of some of the creative work of the participants and Appendix 5C for the key issues that were identified by the practitioners from their creative work)

### **Change as a result of the workshop**

The workshops provided a further feedback loop for me, and also provided the practitioners with feedback and ideas from each other that could impact on their ways of engaging with work-based learning. Thus we were both engaging in praxis spirals from the ‘being intentional’ domain in the methodology

## **Thematic Analysis**

Thematic analysis is one of the most common approaches for analysing qualitative data (Braun, Clarke, 2006), and it can be undertaken in a number of ways. The data for the thematic analysis came from the participatory data analysis process undertaken during the creative reflective analysis workshops described above.

### **Mind-mapping the data**

Cognitive mapping is believed to be a good way to deal with large amounts of data as well as thinking ‘systematically and creatively about messy problems’ (Eden, Jones & Sims, 1983: 10). It was this technique that I used to start the process of theming. I reviewed the transcribed data from the CRA workshops and data that were felt to illuminate the issues were identified and visually mapped using a mind mapping software programme ‘Inspiration’ v9. I mapped these onto a mind map with one key word or phrase and the line number. After every workshop I repeated this process, layering the data and placing similar issues next to each other, or just adding the line numbers to issues that were the same. I used different colours for each workshop so that I could ‘see’ the data in order to make the thematic analysis easier (Appendix 6A). At the end of each CRA workshop the mapping of the previous workshop was shared with the practitioners.

### **Theming the Data**

Once the mind-mapping was complete I reviewed the words or phrases on the mind map by going back to the full transcript to make sure that I was using them in the correct context. I was then able to identify preliminary themes and sub-themes on the mind-maps (Appendix 6B).

### **Rationalising the elements that made up the sub-themes**

I printed out the extracted data that formed each element of a sub-theme and re-read them in relation to the context they were spoken in and in relation to each other. Any part of the data that appeared to be aberrant or insignificant was looked at in more detail to see if it really was the same as something else in the sub-theme or whether it actually related to another element in a different theme / sub-theme. This work was recorded in a new database to maintain the audit trail (Appendix 6C)

## **Revisiting the Concept Map**

Once I had completed the previous stages of the data analysis process I reviewed all the elements to ensure coherence with each other and the theme. Having satisfied myself that my theming was both logical and dependable (Schou et al., 2011) I revisited the concept map to match the new database and to make the themes and the relationships between the themes easier to 'see'. This revised concept map was referred to as 'the tree' (Appendix 6D).

## **Bringing the Themes to Life**

The work to bring the themes to life started with me re-reading the data that made up each theme as a whole, and then undertaking some creative work to try to capture the essence of the theme. I then took each of the sub-themes in turn and illustrated them with data from the 1:1 sessions, supported with extracts from the Creative Reflective Analysis workshops.

The way data are prepared and analysed can inadvertently highlight the impersonal aspects and thus cause objectification of the practitioners. Data that have been transcribed and are analysed simply as 'words' rather than as an integral part of the person speaking them, can be seen as 'filtered' versions of the participant's voice (Bowden, Green, 2010). This can lead to the 'person' who made the utterances 'disappearing' and would result in the practitioner losing their 'voice' and being objectified, with the voice of the researcher becoming dominant.

## **Summary**

In this chapter I have described how I developed a new transformational, action-orientated methodology specifically for use in this study. I did this by unpicking the Critical Companionship conceptual framework (Titchen 2000) and joining it with constructs for a critical enquiry. The methodology is presented as a methodological map, which has two sides – a learning side and an enquiry side - and four domains, Being Person-centred, Being Intentional, Being Facilitative, and Being Present. In order to illustrate how the methodology works in practice I have gone on to describe both the macro and micro design of the study. This includes the methods that were

used for the facilitation, for data collection and for data analysis, which I have linked back to the constructs in the methodology. I believe that the way this methodology has been designed and operationalized will enable the research questions to be answered in a way that aligns with the philosophical underpinnings. This chapter has also allowed me to introduce the practitioners who joined the study. These women worked one-to-one with me in a critical companionship relationship for a year, and also participated in data analysis through the Creative Reflective Analysis workshops. The next chapter will present the findings from the data analysis process that has been described in this chapter. The findings are illustrated with examples from the one-to-one meetings that have been described here and are reinforced with data from the data analysis workshops and my reflective field notes.

# Chapter 5 – The Findings

## Introduction

This chapter will present the findings of the study. The previous chapter explained the methods used to gather and analyse data, and how that data was eventually distilled into themes. In this chapter I will give an overview of the themes and sub-themes and will then take each theme at a time and explore it in greater depth. Each theme is introduced with creative work that I undertook to try to capture the essence of the theme prior to illustrating it.

At the end of each theme I have provided a reflective synthesis of the theme. The chapter ends by synthesising the themes into a model of the role of the facilitator in work-based learning.

In keeping with the ethical approval, the names of people, places and things that might help to identify the practitioners in the examples have been removed or altered. Whilst there are some of the transcripts in this chapter the majority are contained in appendix 7.

## The Themes and sub-themes

Every theme had sub-themes, and the ‘outcomes’ theme had sub-themes and elements.

### Theme 1 - The practitioner’s context

Where I am ‘at’

My manager

What it is like to work here

Work/life balance

### Theme 2 - The relationship

Trust

Feeling more equal

Sitting on my shoulder

Letting go

### **Theme 3 - The facilitative activities**

- Pulling things apart
- Being a sounding board
- Channelling ideas
- Solving problems
- Changing thought processes
- Broadening horizons
- Putting the ball back in our court
- Giving us options

### **Theme 4 - The outcomes**

- Personal change
  - Increased self-esteem and self-belief
  - Confidence
- Changes to professional way of being
  - Authenticity
  - Clarity of role
- Impact on practice
  - Thinking differently
  - Learning
  - Cascading skills
  - Becoming self-sufficient

## Theme 1 – The Practitioner's Context

Stifled or stagnant  
Bounded culture and context  
Shared vision for growth



*This picture depicts the everyday context that the practitioners are working with and in. The background to the picture is green, and that symbolizes the practitioner's home life. The central blue is their work. There are multiple hues of blue in work as well as multiple hues of green at home that signify the complexity of both environments. Inside the work context there are also some boxes that representing the unmoving rigid elements that can be found there. The flame within the work context represents the practitioner – they can be fanned or extinguished by the context. Encircling the work context is a white ring, that may or may not be visible from outside, that signifies the constraining nature of the context. Round the back are two outflows spilling out from work into home, and a small patch of green is just visible caught up in the white ring.*



The theme of context was the first major theme identified. The geographical and clinical spread of the participants meant that there was no one specific context that framed the whole study, instead each practitioner worked within their own individual context and culture which impacted on them as individuals, impacted on their everyday practice and impacted on the learning we did together. Despite the differences there were certain contextual factors that were similar for all practitioners wherever they worked, although the range of experiences within those factors varied widely. It was never an intention of the research to attempt to change the culture of the practitioners' workplaces, although some small, localised changes did take place. Instead the aim was to identify how the context impacted on the participants' ability to learn.

Within the theme of context the sub-themes were:-

- where the practitioners are 'at'
- my line-manager
- what it's like to work here
- work-life balance

### **Where the practitioners are 'at'**

This sub-theme referred to the practitioners as people and how they perceived themselves when they joined the study. It included their reasons for joining the study, their experiences to date, and their motivation as the study progressed.

The decision to participate in the study was a personal one taken by all the participants. About half the practitioners had heard of the research directly, and the other half (one of the Clinical Nurse Specialists (CNS), one Sister, and the three Staff Nurses) heard about the research from their line-managers who suggested they take part. The practitioners hoped that engaging in the work-based learning programme could give them something that they couldn't get in their everyday working environment, although this was based on very little experiential knowledge of work-based learning. For some of the practitioners the hope was that working in this way would help them to achieve specific work-related goals, and this was most obvious in the three practitioners who had changed jobs in the last 12 months. For the rest of the

practitioners their hope was more personal - to grow personally and professionally, to be 'happier and more myself', and to get a work/life balance. There was an overall feeling of having 'nothing to lose' by giving it a go.

It might be assumed that the practitioners who volunteered were already motivated and active. This however, was not borne out in their descriptions of themselves at the start of the study and how they felt about their work. They were instead positioned on a continuum between despair and enthusiasm. At one end there were practitioners like Jade, who joined the study in order to get specific help with a project she was working on. She was enthusiastic, active in work, and loved being a nurse as she described during one of our conversations.

I love working, I really do. The job is challenging, which is good, that is a positive, and it is stressful, but I don't mind. I do I just love nursing. I love talking to people, I love seeing them get better, and I know not everyone gets better, but then you are there for their final days even when they don't. So I do, I just love my job. Jade [J6]

The middle of the continuum contained practitioners like Eve - they had been motivated in the past but they described themselves currently as 'lost', 'stuck in a rut', or 'just ticking over in this everyday stuff'. Their need to change was more personal, and their frustration at the current position was obvious, but despite their desire to be different their ability to change this themselves seemed limited. They didn't know whether engaging with the work-based learning programme would help them break the cycle they were stuck in, but they felt they had 'nothing to lose' by giving it a go.

So that is not the real me that is on this ward at the moment. I go into work, I do my job and that's it. But I am not who I am, [...] and I want to come across, to come back – because I am quite a confident and bubbly sort of person normally – so I want to go back. Eve. (Day 1)

The other end of the continuum was Annie who wasn't enjoying work at all when she joined the research, and later admitted that it wasn't just the job that she didn't enjoy, it was nursing altogether. Joining the study was a 'last resort' that had been suggested by her line-manager.

I really didn't want to carry on with this job at all. I just couldn't see a future for it. It was so mundane. [...] And it just wasn't what I wanted. Annie (A2)

No matter where they sat on the continuum between loving their job and hating it, between wanting practical help or personal help, all the practitioners felt they needed something to improve their ability to do their current job. They were all still committed enough to nursing that they were willing to follow this through and take the risk of working with something (work-based learning) and someone (me) that they thought might be able to provide what they needed.

When the practitioners started to work with me they had certain expectations of what would happen, mainly based on their prior learning experiences. I expected the process with the practitioners would follow a very linear pattern. They would do self-assessments, identify their learning needs, write learning contracts and then we would work through the contracts helping them to learn, change their practice and evidence their learning in a portfolio. The reality is that these things did not happen as expected, partly because of the rapidly changing nature of practice and hence priorities and learning needs changing rapidly, but it was also affected by the practitioners realising that they were participating in this study for their own benefit, and nothing was going to 'happen' to them if they didn't do it.

“Maybe part of the problem, not problem, but obstacle, is that by the end of this, yes I might have learnt x y and z and it is going to make me confident and should make me better at my job. But you don't - it sounds really harsh when you put it like this - but you don't get that certificate at the end, you don't get a pay rise, you don't get.... It's all for me, so if I don't do it I'm only letting myself down, do you see what I mean? [...] So it's not like if I don't do that I'm going to lose my job. [...] I know what I want, but the sort of drive to get me there is really poor”. Emma (E5)

There was no external pressure on the practitioners during their time in the study so they had to be self-motivated. Being in the driver's seat for their learning was a new experience for most of the practitioners and it took them a while to get used to the idea. At times this resulted in some of the practitioners starting to drift, and in other cases the practitioners worked so hard they felt they were in danger of burnout. Once they had got used to this way of working then for most it was felt to work well, and our work together was driven by them and not by external expectations.

## **My line-manager**

The second sub-theme is about the practitioners' line manager. This sub-theme illustrates the relationship that the practitioners had with their managers, and the impact this had upon them and their practice. The role of the line-manager featured very heavily in the practitioners working life and set the tone of their working experience. Line managers had a considerable amount of influence over their staff, and how they chose to use this was very important for the staff that they managed. Line managers varied from those who were interested, supportive and protective of their staff, to those who were only interested in the contribution that their staff could make to meet targets and undertake the job they had been employed to do.

### **Interested in me**

The practitioners' descriptions of their line-managers once the research had begun varied between them being actively interested, pseudo-interested, disinterested, or simply aware that they were participating.

Jade described how her line-manager reacted to her participation in the study.

“after we have had our meetings, if she [ward sister] is around she will want to know if there is anything that we need to do on the ward to support my development” (CRA 1059).

Diane's line manager however could be described as pseudo-interested - after appearing interested enough to ask Diane how she was doing, she walked off while Diane was explaining. This line-manager also allocated a learning opportunity to another staff nurse, even though this had been one of Diane's written objectives that she had discussed with her manager a few weeks previously (D7). These actions may have been accidental or simply unavoidable, as a line-manager has to balance the competing interests of more staff than just the practitioners participating in this research. Whatever the reason these two events coming so soon after each other really demoralised Diane and made her doubt her ability to actually achieve what she wanted to achieve.

Melanie's line manager worked remotely from Melanie and was disinterested in what she was doing in the study, and only appeared to be interested in how she was functioning in her role. We had been working together for almost 2 months before

Melanie and her line-manager had a meeting. Melanie enthusiastically attended the meeting with all the work we had been doing, and I met up with Melanie immediately afterwards.

“About my [...] plan she just said, ‘you couldn’t possibly keep to that’, but she didn’t look at it, she didn’t know what any of the abbreviations meant, or how I would make it work. [...]. So immediate criticism rather than seeing what we have done [...]”  
Melanie (K5)

Melanie was upset that all the work she had done had been dismissed so easily, and said her response to her line-manager changed from being open and honest to one of resigned submission, “I just say yes and agree to everything”, and further identified that without the support of the one-to-one meetings with me she would have given up her post and returned to her previous role.

The final type of line-manager was aware but remote. Although not actively involved on a day-to-day basis with the practitioner, these line-managers were still aware of their participation in the research, and the impact on them both as individuals as well as practitioners. Annie’s line-manager was one of these. She stopped me when I walked through the hospital and said that she was impressed with Annie and the way she had developed over the last 9 months, and particularly commented on the way Annie had responded to a recent assessment visit. Her view was that Annie was ‘transformed’. I asked the line-manager if she would send an email to Annie repeating what she had just said to me, however it never materialised. Annie was really chuffed when I told her what her line-manager had said, but if I had not shared the message Annie may never have had that feedback.

The practitioners’ individual responses to these managerial positions varied, but in general it was the actively interested manager that was seen as ‘supportive’ and gave added motivation to the practitioner. The impact of the line-managers who took one of the other stances appeared to be related to how closely they worked with the practitioner. Thus a ward sister that is perceived as not really interested in what the practitioner is doing can have a devastating effect on their commitment. For a practitioner whose line-manager works more remotely however, the perceived lack of interest seemed to have less of an impact. This may be due to the level of autonomy of the practitioner herself, so that the staff nurse relies on their learning time being

‘given’ to them, and without the active interest of the sister they feel increasingly guilty about this. The nurse in an autonomous position however organises their own time, and so the time that is taken up for learning only impacts on themselves. The nurse in an autonomous position was also in a better position to find someone else who was ‘interested’ in what they were doing, so their commitment didn’t appear to suffer that much.

It would be unfair to place the responsibility for an effective relationship solely on the manager as to be most effective all relationships have to be two-way. In a hierarchical system however, it is the more senior person that would be expected to take the lead in setting the tone for the relationship, and in the examples above there are at least two bands difference between the practitioners and their line-managers.

Emma and her line manager, who were actually specialist nurse colleagues in the same team, illustrated the benefits of a two-way relationship. Emma’s line-manager had been interested in her learning from the start, however Emma felt protective of our relationship and our one-to-one meetings and did not share anything about them. In turn the line-manager did not enquire of Emma how things were progressing as she felt our meetings were ‘private’. About half way through her time in the research Emma had to share the outcomes of our meetings with her line-manager as she needed her help to take some work forward. This had a hugely positive effect on them both, as well as on their service, as Emma reported.

“what I have started doing is as soon as I can [...] try and touch base with (line-manager) and say [...] we have talked about this, and actually how about if we change something, do something – [...] and she might say “oh that won’t work, but we could do it this way” or she might take on board what I suggested or just things that I have talked through, things that I think are important. And that gets her thinking then, and she might go away for a day or two and then say “I was thinking about what you said” and it just leads into on-going discussions about stuff. So in the beginning I kept this quite separate from (line-manager) thinking this is my thing with you, and she would never ask so I would never tell her, but more recently I have started discussing more stuff with her and involving her more in it. [...]. I think she has got a little bit excited now about the service and things we can do, and she keeps coming up with new ideas as well” (CRA 4717 & 4851)

## **Sticks up for me**

The role the line manager played as a ‘protector’ was also important in the study. The impact of this protection on the ability of the practitioner to learn was twofold and came down to the difference between being protective *of* staff and creating a protective environment *for* staff thus enabling them to act.

For the line manager there was a tricky balancing act between shielding staff from additional demands yet still enabling them to have new learning experiences. In the main the line-managers who were put in this position tended to be ward sisters or equivalent who often acted quite paternalistically. They were aware that their staff were ‘busy’, so when new things came along there was a tendency for the sisters to do the new thing themselves or decline the opportunity, rather than pass it on to their staff. Although well-meaning these interventions were invariably made without consulting their staff, and inadvertently led to staff either not being involved in potential learning opportunities, or to them being excluded from certain parts of change projects.

An example of this was demonstrated by one of the practitioners in the study. Catrin was herself a line-manager and was expected to work with her staff to develop a ‘vision’ for the ward. However she knew that the ward was busy and the staff were under pressure, so when one staff nurse came to her with a ‘vision’ which she had developed by herself, Catrin asked her if she could use this for the ‘ward vision’. Catrin knew that it wasn’t a ‘ward vision’ but said that as the ward was so busy at the moment she didn’t want to put the additional work of developing a team vision onto them as well (C8). This episode highlighted how by ‘protecting’ her staff from extra work they did not get the experience of developing a ward vision, and ultimately it meant that the vision that was adopted could not be used for its intended purpose.

The second form of protection that a line manager could provide was creating a working environment that was enabling. This was demonstrated by Eve’s line-manager after a complaint about Eve from a colleague in a neighbouring service. The complaint was that Eve was working outside her job description and doing more for the patients than she should be. The easy way out of this difficult incident would have been to hold Eve back and reduce the service she was currently delivering to match that of the nurse that complained. Eve and I did some work together around this, but it

was the support that she received from her line-manager in a meeting with her opposite number that not only enabled Eve to continue to offer an excellent service to patients, but it also enabled her to feel safe enough to start to suggest and enact other change within the service. Prior to this Eve had been ‘just waiting until I have been there longer’ before suggesting change (F5). In the next data analysis workshop Eve noted

I feel more empowered in this job. And our boss is much more supportive...she is very open to ideas and, always asks for your feedback and opinions on things (CRA 7430).

This safety was missing for Melanie who was currently between line-managers (her previous one had left and the position was currently vacant). Melanie had cause to raise concerns about fundamental aspects of care on one of the wards. As a result things became very difficult and she was criticised and subjected directly to both overt and covert threats from some senior staff within the hospital. Melanie had no-one to ‘stick up’ for her during this time, and a practitioner with less personal fortitude may well have been put off ever taking the risk of raising concerns again (K9).

## **What it’s like to work here**

This sub-theme contains evidence from the practitioners about their everyday reality when they went into work and centred on how confident they felt with what they were doing (their personal competence), how comfortable they felt with who they were doing it with, and their ability to change what they were doing.

### **Confident in my competence**

The need for nurses to be competent is important for the safety of patients, but the need for nurses to feel confident in their competence was important for their own well-being. Being aware that you are not competent can be a frightening place to be, and just the thought of this had in the past prevented some of the practitioners from voluntarily moving jobs or trying new roles.

All the practitioners recognised that when they were in new roles they had to learn new knowledge and skills, but the pressure that they put on themselves to develop quickly was often excessive. The complexities of trying to develop a role and learn new skills inevitably impacted on their home lives and personal well-being. This was



demonstrated by Jade when I met up with her a few weeks after she had started in her new role, which was a promotion in the same clinical area. She was due to take a week of annual leave and had been explaining to me what she was planning for her time off. It included a couple of meetings in work, which she felt she ought to go to, and some other things that she was going to do at home 'for the ward'. She explained

There is a lot more pressure being put on my shoulders - but I put pressure on my shoulders as well. Pressure to develop, that's the thing. Because I do put extra pressure on myself to make sure that I do well in my job. (J8)

In the process review at the end of this session however Jade admitted that she was finding things difficult.

I just feel myself sometimes like I want to cry. And I don't actually have a reason for wanting to cry. It's just that it is too much. And not that I want to cry, and there is not even one reason why I should cry, but it's just everything maybe. (J8)

Remembering that it was only two months previously that Jade had described how she 'just loved nursing' despite the stress, this was a step change. She was reluctant to say anything to her line-manager however, as she didn't want her to think that she 'couldn't cope'.

To obtain support with their clinical learning there was a need for practitioners to identify clinical experts who were willing and had the time to share their knowledge. One example of this was Emma who had been in a Band 6 specialist nurse post for a few months before she joined the research. Her specialist field was an area where I had limited knowledge, but I was helping her to apply her learning by asking questions. The idea was that I would ask the questions that an 'average' patient might ask, and she could explain things to me and thus highlight what she had learnt since our previous meeting and what she still needed to do some more work on. When she was unable to answer some of my questions she went to her line-manager (a band 7 specialist nurse) to find out the answers. She got the questions answered, and it also made the Band 7 realise that she needed to do some teaching with Emma.

"she got this textbook out that actually had quite a good way of explaining it and so she talked me through that as well. So it was quite good actually. It prompted a little session. So those questions that you fire at me that you think are silly questions are actually very helpful questions". (E5)

The lack of planned learning support for nurses when they moved clinical areas or changed role seemed to be spread across the board. A number of the practitioners recounted occasions in the last few years when they were ‘moved’ by their line-manager from one area to another, with one feeling as if this had been done deliberately to destabilise her as she was felt to be ‘too confident’, and another feeling as if this was a ‘punishment’ for doing something wrong. Whilst the intention of the moves may have been for the practitioners benefit this was not how they were perceived, and none of the practitioners could remember being provided with structured support when they were moved, although some were given objectives that had to be achieved. An example of this was a learning opportunity that was provided for one of the practitioners during the research. Gwen was an experienced nurse who had a complete change of direction in her career a few years previously and was now working as a staff nurse again. At the start of the research she was seconded into a Junior Sister post for 6 months as a development opportunity, however during the 6 months she was moved to 4 different areas. She found the whole process difficult and didn’t feel that she had learnt anything from her experience. She identified that if she had been less experienced then she may not have coped with the moves.

This lack of planned or structured learning when a practitioner moved to a new area may help explain why a significant number of the practitioners in the study were ‘stuck in a rut’. They didn’t feel confident enough in their own competence to enable them to actively seek out new opportunities and move themselves to a new area.

### **Avoiding conflict and confrontation**

Throughout the study the practitioners talked about the things they found difficult and needed help with. One of the most common was the dislike - and consequent avoidance - of conflict. The conflict that was being referred to was doing anything that might ‘upset’ a colleague, and the reason for the dislike appeared to be a fear of being confronted. This was most apparent for the Band 5s who were afraid of being labelled as “too big for my boots” or faced with the response “who do you think you are?”

The most common thing that was avoided was giving unsolicited feedback on a colleague’s practice. This has significant implications for standards of care, because as one of the practitioners identified, it is often the nurses or support workers whose

practice needs to change the most that are more likely to be actively or passively aggressive if challenged.

The ones that I know are going to confront me back are the ones I am a bit nervous about, and they are the ones that I let slip. [...] I wonder whether the reason I can challenge (the one's I get on with) is because I know they are good at what they do. And I know that sounds really stupid, but the ones I get on with are the ones that I feel work the best on the ward. [...] But there are a couple that I feel really, really nervous about, and those are the ones that need to develop, and those are the ones that will confront me as well. Jade (J3)

This difficulty did not only exist when highlighting poor practice. One practitioner described how she found it difficult to raise any issues or suggest change with her ward sisters, because they became defensive and the practitioner then felt as if she was stabbing them in the back (CRA 6034). Another practitioner found that her relationship with her ward sister changed when she got a promotion from staff nurse to junior sister. She found it difficult to adjust to this but was unable / unwilling to say anything in case she upset the ward sister and made things even more difficult (J8/9).

This fear of being seen as 'too big for my boots' was also apparent for practitioners who were new to an area. Things that need to be changed are often most visible to someone newly arrived into an environment or culture but being 'new' was another reason for not saying anything.

"So you can see what needs changing, but at the same time you are trying to settle yourself into the team and there is an already established network and things there, so for me it was actually getting my confidence up enough to say "why don't we look at, or could we look at doing this and things" (CRA 8559).

The fear of what might be said about the practitioners if they upset anyone was not without its foundations. One of the wards that Melanie had patients on was in difficulty. There were significant leadership issues on the ward; problems had been highlighted by patients in a satisfaction survey; and there were issues around the delivery of fundamental nursing care. During a ward round Melanie pointed out to a staff nurse that a patient they had just seen had a very dirty mouth, and she asked her to please take care of it. Melanie felt she made the request in a kind and considerate way, but the junior sister later informed her that she had upset the staff nurse concerned (K9). Melanie eventually felt that she had no option other than to formally raise her

concerns about the ward to the Senior Nurse for the Hospital, and this led to Melanie being accused by the general manager of getting too involved in the ward. A few months later when nothing had really changed and Melanie had raised concerns again the Consultant advised her to 'watch her back' as the Nurse Manager had told him that she was stirring up trouble and stepping on people's toes. In our next meeting Melanie explained how this made her feel

If I had been on my own (without a Critical Companion) I wouldn't nearly feel as strong to fight the culture, but I still feel worried that perhaps they might find a reason not to give me the job in September because they see me as a trouble maker and they could make my life very difficult, and that makes me feel quite uncomfortable. It doesn't make me want to stop challenging practice or wanting to change culture or wanting to help influence for the better, but it does make me feel uncomfortable and worry about it. (K13).

### **Making changes**

This sub-theme was about the practitioners' perceived ability to make changes to their current practice, and what helped or hindered their efforts to do this. Although some of the practitioners had no problems suggesting or implementing change, most described situations in their work areas that impacted on their ability to influence practice or introduce change. One of the key things was whether or not they were working with colleagues who had the same vision as them. This work ally, no matter what profession, made the process of influencing practice change much easier. Not surprisingly the participants in the research who were themselves direct line-managers spoke of the importance of inspiring their team to the same vision. Working with or in a team where they did not share the same end goal, or there was felt to be competition in trying to achieve it, became an additional barrier that had to be overcome.

Being enthusiastic and committed in work led to a desire to change so many things and then an inability to do that, either through lack of time or perceived lack of 'power' led to increased frustration and often disengagement. This disempowerment was particularly felt to be the case when they were 'only Band 5s', although it has to be said that the feeling of not being high enough up the hierarchy to achieve change was a common feeling that was not just confined to those practitioners in Band 5 positions. For many practitioners their experiences of change were more about 'implementing'

external practice improvement initiatives rather than identifying and planning a change themselves.

I come from a background where change... I have never been allowed to suggest change. It has always been “these are the new guidelines, this is what we are doing, you lot are doing this”. And when I have tried to suggest change before, it has been blocked immediately as “no, it’s not happening” and so you get motivated about things, but you just haven’t had any scope to do anything, so it’s just... What is the point in the end? (F5)

Three of the practitioners were involved in specific practice improvement projects. For one practitioner this was the reason she joined the study – to get help with the project. For the majority of them their ‘involvement’ started out as being asked to ‘take a lead’ in the project, but the reality was they were just ‘doing things’ for the project. Helen was asked to ‘take a lead’ on the implementation of a project into her ward that had national backing. When we first spoke about it Helen didn’t seem to understand much about the project, and didn’t know what she was actually meant to be doing beyond ‘giving information packs to patients’. The ward sisters were doing most of the organising and the work for the project even though the additional workload was becoming difficult for them. After Helen had been back to the sister to find out more, one of the ward sisters came in to our one-to-one meeting to explain, and then really started to involve Helen

**Ward sister** –What shift are you working Thursday? Because we have the (X) group meeting and they want to see our progress up to date. It would be good if you could join us Helen because then we could do the presentation again, and you can get all the project background. [...] And also we have meetings every Wednesday with the Patient Experience Manager, so that is another thing you could do. You can attend all these meetings. Definitely, take the lead, because the Patient Experience Manager is looking for somebody to grasp it. (H2)

The change in Helen’s interest in the project when she actually felt included was dramatic. In another project a similar thing had happened. Jade had made the initial suggestion to implement a research finding that she had read about into practice. She had been told that she would ‘lead’ it on the ward, however the latest part of the planning had taken place without her so she was unsure exactly what her role was now.

So I read the research article and we said “shall we actually do it”. So it was sort of like a joint - I don’t really know who the lead is

because nobody said. It was said that I would lead it on the ward, but then I am not actually involved in any of the planning, do you know what I mean. [...].- Jade [(J2)

In both cases Helen and Jade felt that they were in the dark with regards to the project and were to some extent trying to ‘catch up’ with what had been planned, having either not been involved from the start or from missing a planning meeting. Although the practitioners were meant to be ‘taking a lead’ their ability to attend planning meetings was constrained by their off duty. This partial involvement was frustrating for them both. A similar thing was demonstrated in the third project, which was the implementation of the oral care bundle that had been delegated to Eve. In this instance everything had been planned centrally (teaching materials, assessment, care plans, and equipment) and it was just Eve’s role to implement/deliver it. She had no say in what she had to implement, and even where she felt professionally that the care delivered through the care bundle was not appropriate for some of the patients on their ward, the mechanism to try to change anything was tortuous to the point of being virtually impossible. The only thing that Eve could influence herself was exactly how she tried to engage the staff with the project (J1).

For some of the practitioners who did attempt to make their own practice changes during the course of the research, there was a feeling that as they were proposing changes or pulling together papers to support the change they were inadvertently exposing associated areas of practice that were also not as expected.

I have a feeling that I have opened a whole can of worms with this as (senior nurse) didn’t know that we were doing home visits. How can she not have known because we hand in our time sheets to her with the mileage on it? So how can she not know? (E10)

This caused additional work and, in the process, caused them to feel exposed and vulnerable. In addition, trying to find out the ‘right’ people to approach with practice development ideas was complex, particularly when a project spanned the acute and community sector. This had the effect of making relatively simple changes actually seem much bigger than were ever intended to be, and without support these would have foundered as the practitioner found it all too much effort on top of their already busy day jobs [E13].

The ability to change practice was therefore difficult with many practitioners thwarted at the outset. For those who were allowed to continue, the process was made more difficult by having to do the work for the change in addition to their normal work, which often meant having to take work home or stay in work in their own time.

## **Work / Life Balance**

This sub-theme is about time and includes how the practitioners used their time in work, how much control they had over their time, and the impact that time in work had on their home life.

### **Spending time carefully**

Time was a significant issue for the practitioners, and as mentioned above, most things that were done in their work-place were expected to be done in addition to their usual clinical work. This also applied to the time that the practitioners needed to meet up with me. The practitioners who had a degree of autonomy over their own diaries were able to fit me in even when their work was very busy, and for these practitioners it was at the busy times when they felt they needed to see me. For the practitioners who worked as staff nurses on wards time-out was difficult to arrange, and in general I had to meet with them before or after their shifts and then they were reliant on their managers to get the time back. This did not always happen. Although all had agreement at the start of the research for the time commitment required this was not always honoured, especially as the year progressed.

“Its work pressure for me I think. It’s fitting it in because I am part time. And because this has been ongoing, possibly my manager isn’t as keen now as she used to be. So it’s not a priority for her to let me come away when we are busy” (CRA 4288).

Those practitioners who struggled to get release time from work all elected to continue in the critical companionship relationship and the research despite this. The most difficulty with arranging one-to-one meetings was caused by night shifts. Two practitioners did a considerable span of night duty during the research. For Jade who did her night duty in the middle of the research finding time to meet was challenging. For Diane who did her spell (6 weeks) of night duty at the start of the research things were much more difficult as she never felt that she was able to ‘get going’.

The practitioners with autonomy in their roles tended to be Specialist Nurses and for most of them the issues with time related to being 'lone' workers, which meant that when they were on holiday or off sick their work was just left for them to pick up on return. This added to their already pressured roles and had resulted in one CNS (Annie) who had been in post for 3yrs never having taken 2 weeks AL together (A). For the two practitioners who were based in the community arranging meeting time was just as difficult as there was limited availability of staff to cover gaps when there was sickness. This left the teams very short staffed and therefore spread very thinly to cover their calls and resulted in quite a few meetings being cancelled at relatively short notice. Because they tended to work 9-5 it also made meeting before or after a shift more difficult.

Despite the difficulties with time the practitioners were all still keen to meet. Practitioners identified that the time invested in talking with me benefitted their practice in the long run even though it increased their workload in the short term. Trying to find the added time required to action anything they wanted to take forward from the meetings was difficult however. This was not just confined to things they wanted to action from our meetings but could just as easily apply to other ward-based things they had been asked to take on by the ward sister (see making change above). Using one's own time to achieve delegated activities appeared inevitable and was almost expected, and a feeling that this commitment was just one way – from the practitioner to the Health Board - led to considerable feelings of negativity.

“Everything that I did for that oral care health promotion board thing was my own time, my own work. And I was even having to put it up on the wall in my own time. You don't get anything back from your ward manager, so you almost feel “what's the point” (CRA 7316).

It is difficult to know if this happened because their line-managers didn't realise, or whether it was simply being subconsciously ignored because of the difficulty with trying to give staff time back in an already short service.

### **“My kids need me sometimes too”**

Trying to juggle work and home life was a constant balancing act for the practitioners, and with little or no time in work to undertake learning activities or write reflections they either had to be done at home or not at all. The need to keep a work/life balance



also impacted on the practitioners' ability to action things after the meetings. Those who worked part-time all spent some of their additional day off doing work-related activities. Recognising this and taking appropriate action was a major step for some of the practitioners. There was also a need to ensure that the meetings themselves and the work generated from them didn't add to the practitioner's difficulties with achieving a work/life balance.

Apart from how knackered I am in the evening, there isn't any reason why I shouldn't sit and do an hour or so a couple of times a week once the kids have gone to bed. But the kids are going to bed later, and I'm shattered, and then I think I just want to flop, and then I think if I have got time to do this there is loads of home stuff that when I get an hour to myself I need to do. (E5)

What was going on in the practitioners' home lives also impacted on our one-to-one conversations. When there were events happening at home it made the practitioners less able to work with challenge, even if they had not initially identified these events as significant. In addition, having responsibilities as carers also impacted on the practitioner's ability to undertake additional work-related activity at home. On one occasion I found myself 'giving permission' for a practitioner to take a break and have a whole weekend 'off'. This was because I knew that since taking up a new post the practitioner had put her heart and soul into the role and getting a work/life balance had been such an important part of her learning (Reflective Field Notes). Ensuring an appropriate work/life balance also appeared when one of the practitioners was considering undertaking further academic work. She felt that as a CNS she ought to have a degree, something that had been mentioned specifically by the Director of Nursing. At the same time as she was considering her options for undertaking a degree she was struggling with her inability to spend time with her children.

I am getting upset now (*crying*) and it's not because of you. [...] Feeling guilty that I am not there for my kids. I have felt that a lot today. [...] You know I have just spent the last week trying to sort out the summer holidays, so that I can focus on working, and I am not going to be there for them. And my kids need me sometimes too, you know. It's so hard. It's so hard. Melanie (K14)

It was not just those practitioners with children who found difficulty with balancing work and home life. One of the practitioners was moving to a new house to live with

her mother and had to accompany her on hospital visits etc. She had to delay her start in the research because she didn't know "if I am coming or going".

## **Reflective Synthesis of Theme 1.**

Within this study the issues that were identified by the practitioners that shaped their everyday context were sub-themed as 'where they were 'at'; their line manager; what it is like to work here; and their work/life balance.

The findings taken as a whole paint a picture of a very variable context. Practitioners views of their current work situation could be anywhere between 'loving it' and 'hating it'. Despite this their commitment to nursing was strong. They therefore put a lot of pressure on themselves to function well in the job and develop competence, but this itself could impact on their ability to engage with learning. Their commitment was also affected when work was encroaching into their personal life.

Their ability to do anything in work was affected by how much control they had over their working environment. The things that made a difference to this were their position in the hierarchy, their previous experiences of attempting change (learned helplessness), and their managers who varied between being interested or disinterested, between 'looking after' their staff in a paternalistic way, or 'looking after' their staff by creating an enabling environment; between wanting them to participate in change but hampering their ability to do so.

How comfortable they felt to suggest or enact change depended on how 'safe' they felt in work. This was not often verbalised as 'I don't feel safe', but was referred to as 'disliking conflict', 'don't want to upset anyone', 'opening cans of worms', 'feeling as if I have stabbed them in the back', 'waiting until I have been there a bit longer', not wanting to be thought of as 'too big for my boots'.

The research question that this theme helped to answer was 'What contextual factors help or hinder work-based learning'. The findings above have helped to clarify that the contextual factors identified above have most of their impact on individual work-based learning through the effect they have on the learner. Thus there is a combination of overarching factors that appear to make a difference to the nurses' ability to engage with work-based learning.

- Family life, everyday work experiences, and personal values and beliefs had an impact on the **commitment** of the nurse both to their job and to their learning.
- Relationships with colleagues and their line manager, together with their own feelings of competence in their role influenced **how safe they felt in work**.
- The hierarchical system and their line manager's leadership approach influenced how much the practitioners felt **able to act**.

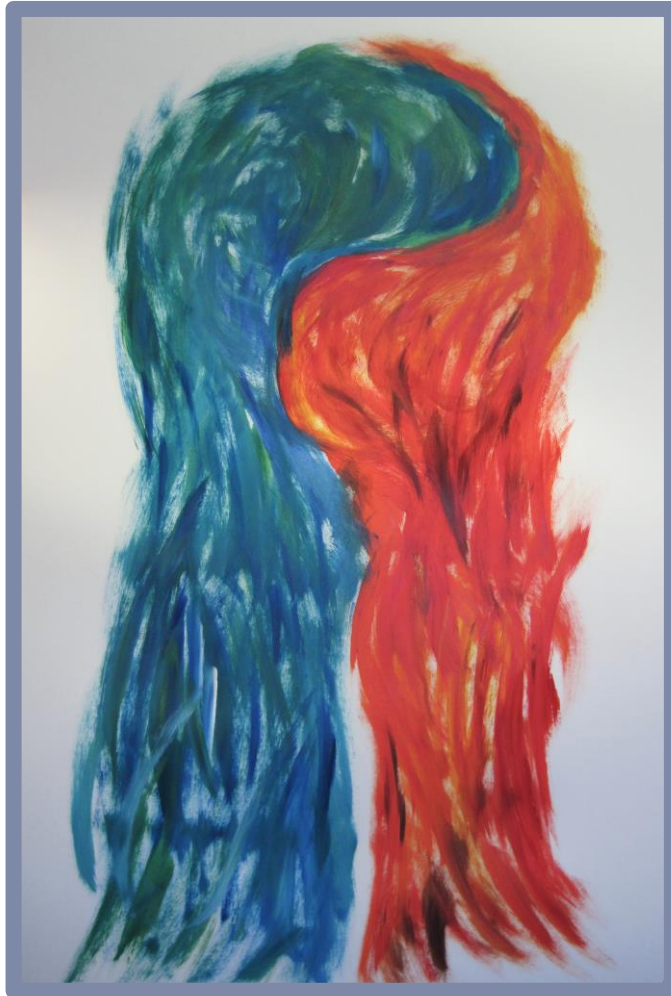


*Figure 19- Reflective Synthesis of Theme 1*

It can therefore be seen that these three factors – commitment, feeling safe, and the ability to act - combined together in the practitioner and influenced both their ability

to learn, and their ability to turn that learning back into outcomes. It was therefore the nurses themselves and the people that they were working with that determined exactly what each factor looked like and what impact it could have. All three factors have a continuum within them, which demonstrates their usefulness in illustrating a whole range of contexts. It will be these factors that are discussed in the next chapter.

## Theme 2 - Facilitator / Practitioner Relationship



Honesty and trust  
Relationship deepening  
Growing partnership

*The picture depicts the relationship and how it has developed over time. When we start working together we are walking close to each other, but there is a clear gap between us. Slowly the gap closes until we are working together as two parts in a circle.*

The word companionship is defined as ‘a state of being with someone’ - a type of friendly relationship (WordWeb), whilst a companion is a companion *to* someone and implies that they are chosen rather than imposed. The facilitation framework of Critical Companionship (Titchen, 2000) has the relationship between the companion and the practitioner at its core, and the relationship domain is also a key part of the methodology for this study. It is therefore not surprising that the relationship between the facilitator and the practitioners was the second major theme in the findings.

The relationship between the practitioner and the facilitator was set up before the first one-to-one session by drawing up a contract that set out what they could expect from each other while they were working together. Undertaking all this preparatory work was important, but none of it guaranteed that an enabling relationship would occur. That had to be worked on.

Within the theme of the relationship, the sub-themes that were highlighted by the practitioners were

- Openness, honesty and trust
- Feeling more equal
- Sitting on my shoulder
- Letting go

In this section I will be illustrating both the development and the maintenance of the relationship between me and the individual practitioners using words and creative work from the data analysis days; and extracts from the reflective process reviews and my reflective field notes.

## **Openness, honesty and trust**

This sub-theme contains the key elements of the relationship – openness, honesty and trust. It also illustrates how, as the trust deepened, the openness and honesty developed.

Trust is the key to an effective working relationship, and this takes time to develop. In addition, it had to develop whilst we were working together. I believe that we listened and responded to each other as developing companions rather than as colleagues in a

formal work relationship. This sharing, coupled with the fact that the practitioners felt that I was non-judgemental and unbiased, helped to deepen our relationship.

“[...] in the beginning if they (the meetings) were more chatty then that was us getting to know each other, and now we know each a bit better we don't need to chat so much (CRA 4509)

The practitioners made every effort to be open and honest, although they did admit later that they were initially 'selective' about what they shared with me. We all saw this as an indication that the level of trust was increasing.

“I think that the more that I meet you [...] the trust gets deeper. It's easy to say you trust someone, it's easy to say that you could challenge someone, and not offend them. But it's building that relationship isn't it. And I feel that stronger and stronger every time we work together. Melanie (K9)

This preliminary work of consciously developing the relationship was not required with Gwen as about 20 years previously we had been colleagues for eight years. Although we finished working together 12 years ago and hadn't had a lot of contact since we slotted back together quite easily.

To be honest I think I probably found it easier talking to you - because I know you - rather than talking to someone else, [...] You know perhaps I wouldn't have been as relaxed – Gwen (G1)

The personal stories that the practitioners chose to share as we were getting to know each other were generally 'safe' subjects, with the practitioners disclosing a socially acceptable level of personal detail that I was able to use to tailor the facilitation activities that I used. Once the trust had developed I spent very little time focussed on or even thinking about our relationship – it just was.

It would be misleading however, to assume that this trusting relationship was apparent with all the practitioners all the time. On one occasion I was concerned that I was being manipulated, but for a variety of reasons I felt that it was not the right time to challenge the practitioner or verbalise my feelings, so I decided to just to ride with it for the moment. In my field notes at the time I identify that this was demonstrating intentionality and salience – knowing when and how to challenge - but on reflection now I think there was an element of cowardice on my part. My failure to address this meant that for a while I was constantly aware of and thinking about our relationship.

This impacted on my facilitation of her learning, and I captured an example of this in further field notes

*“I wonder if I am now so busy thinking about what I am going to do or say I am forgetting to listen to her and what she is saying, and therefore missing potential learning opportunities. [...] I think I need to be careful that I am not simply being used to lend legitimacy to her way of working [...]. In my efforts over the past month to be supportive, I think I may now be reinforcing her attitude simply by not drawing attention to it”.*

*Field notes. Feb ‘12*

### **“Feeling more equal”**

This sub-theme is about the dynamics in the relationship, how that developed, and how it was seen as being different from other work relationships. At the start of our time working together I consciously worked on trying to develop this relationship. I was mindful of my body language; of suggestions of power and of the way I talked and told ‘stories’. I considered carefully where I sat when I went to meet the practitioners, and I made sure that I shared parts of myself in the way I was expecting them to share of themselves. Despite my best efforts, some of the practitioners still felt that I was like a teacher and they were a student, and the questions that I asked was an attempt to somehow ‘test’ them.

*“I do feel a lot more that I can talk to you now, whereas at the beginning it was always more like a teacher type thing. Now you feel more like a friend. [...] I felt like I was being tested and challenged (lots of agreement with this)” (CRA 499).*

This may have been due to their expectations of what work-based learning would be like, coupled with their previous experiences of learning and being taught. There were a few times however when I too identified that our one-to-one conversations felt more like ‘teaching’ than facilitating, particularly when I had to be more directive at the start to enable a practitioner to actually do something. It was difficult to develop a trusting facilitation relationship when the practitioner appeared unable to relate to me as anything other than a teacher, although this may have been due to us not being able to spend much time together as she was on night duty.



All the practitioners felt that the relationship between us was different to the relationship between them and their ward sister/line-manager, as they had no accountability to me for what they were doing.

“But also I think that because you are not my manager and I only ever have contact with you regarding this, I have no other sort of commitment to you. Whereas if my Critical Companion had been say the ward sister or some sort of manager, you would feel like you would be trying to impress them or you would feel a lot more under pressure,” (CRA 521)

As they began to realise this the practitioners also started to be more open and honest about the things they were ‘holding back’ from me before. This ‘external to everyday work’ relationship was particularly useful when the practitioners were actually having difficulties with their line-managers.

It’s like having someone who knows everything, but is also a friend  
– not in dark blue (CRA 5884)

This lack of professional accountability to me empowered the practitioner to say no to some activities. This meant that when they did undertake an activity they really owned what they did.

“I think that is why I enjoy it, is because it’s not a teacher / student relationship. I haven’t got to prove myself that I have written you this essay or anything. It is about MY journey, and what I have learnt along the way, and what pathways have been opened up and what things I have been exposed to that I wouldn’t have been exposed to anyway. That is my learning... (CRA 7801)

In the creative work undertaken at the start of the first data analysis workshop two of the practitioners captured both the developing relationship and the subsequent changing dynamics (Appendix 7A 1&2). This highlighted that although I had made every effort from the start to be person-centred, and so I believe had they, it was only after a period of time working together that the relationship had developed into a partnership of equals.

For me as the facilitator when I started the field-work I felt overwhelmed by having five practitioners to facilitate at the same time. I had never done work like this before and I felt that I was being swamped. I was taking the participants issues personally and was trying hard to be very supportive. I believe I ended up being quite paternalistic instead and, as can be seen, the practitioners also felt the relationship was hierarchical.

When undertaking some reflective work about the issue of relationships and boundaries (Williams, 2012a, Williams, 2012b) I painted some pictures that actually captured what I felt was my current situation, with no boundaries between me and the practitioners. It helped me to see that I was indeed being obscured (see appendix 7A 3). Following on from this work I was able to re-position my view of the relationship as more purposeful. What the practitioners eventually described as a ‘partnership’. A partnership implies a co-operative relationship between people who agree to share responsibility for achieving a specific goal, and I think that is what we achieved.

Throughout the work that we did together, and despite the occasional comment that the session had been a “good counselling session”, the focus of our conversations always remained the practitioner’s work. This surprised the practitioners at the time, but all agreed that although they talked about ‘personal’ things, these never became the focus of the work.

**Caroline** – So are you glad that there isn’t (more personal work), or do you wish that there had been more?

**Emma** – [...] I don’t think it has needed to be. Because we have had enough to talk about and enough to learn about as we have gone on. In some ways it is quite nice, quite fresh not to have to involve the personal side of things and just get on with the work. (E10)

### **“You are on my shoulder”**

This sub-theme was about the enabling features of being in a trusting partnership. The practitioners found that being able to discuss events that had happened, or preview events that were due to happen provided them with a safety net, with someone they could run things by and try things out, and this gave them increased confidence when they were on their own (see ‘Being a Sounding Board’ in the next section). This increased confidence seemed to be associated with the feeling that I was on their side, or actually with them.

“It’s really strange, it’s so hard to explain because I am not sure what you do. It’s like you give me courage to do stuff, like you are on my shoulder” Catrin (C10).

Similarly, in one of the Data Analysis workshops a practitioner identified:-

“So I was coming in and basically upsetting the apple cart, which shouldn’t have fazed me, but at the time I didn’t have anybody behind me to do this. Whereas now, all of a sudden, I feel it doesn’t matter and I have got backup (CRA 8754).

A number of practitioners also described occasions, again when I wasn’t actually there, that they were able to use my virtual presence for reassurance or to enable alternative ways of thinking. In these situations practitioners asked themselves “What would Caroline do now?” or “What would Caroline say to me now?”

“So instead of ringing round people and giving in, I thought we need to change this, we need to do something a little differently, which is ‘Caroline thinking’. “What would Caroline do in this situation?” (CRA 4232)

And similarly when Eve was unable to complete the documentation audit one month and got into trouble from her ward sister

“Driving home I thought “what would Caroline say to me now?”. And I thought she would tell me “you know what, you put the patients first. [...]. And if I haven’t done an audit – so what”. (CRA 8968)

## **Letting go**

This sub-theme was closely linked to the previous theme and was about the need to prevent dependence in the practitioners.

Working closely with another person always runs the risk of the partnership becoming more important than the work, Despite wanting to promote independence in the practitioners quite a few of them expressed the thought that they wouldn’t be able to ‘let me go’ at the end of their time working with me (E11). Melanie was one practitioner who was always aware of this possibility.

“I feel that sort of ownership of each other. I get a bit jealous – and jealousy is a little bit to do with those feelings – when you are off with one of the other participants. It’s ridiculous, but you do have those feelings [...]. Jealousy is maybe too strong a word for it, but “you are mine, get off her!” – Melanie (K13)

This danger of dependence also played out in the activities that the practitioners undertook. As mentioned previously the practitioners had no professional accountability to me and therefore had no need to undertake any of the work that I

might suggest. For most of the practitioners this meant that *they* made the decision whether to do something or not, and quite often the decision was not to do something – either due to pressure of work, or because they felt that something else would be a better option.

In addition, one of the goals of one-to-one facilitation work is to enable the practitioners to learn how to manage their own learning, and thus become independent. For the majority of the practitioners this was being achieved, however there were occasions when practitioners slipped back into the “I’ll do it for you” mode.

**Catrin** – OK I’ll do it. I’ll do it properly, just for you

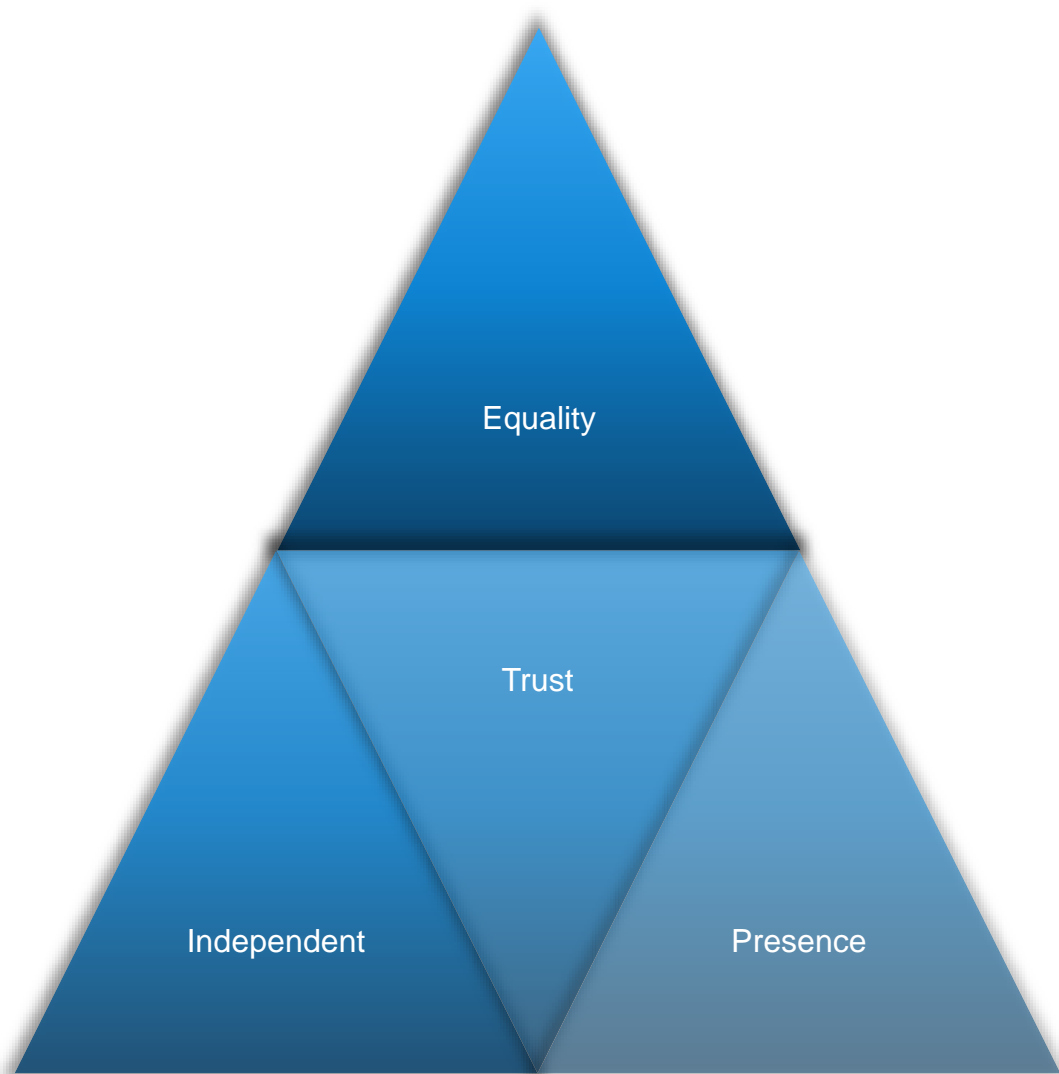
**Caroline** – No it’s not for me, it’s for you

**Catrin** – OK. You know it’s going to be really hard to write it now without just writing it to please you

**Caroline** – Well let’s make a pact then. If you are writing it just to please me, then please don’t. (C14)

## Reflective Synthesis of Theme 2

The relationship between the facilitator and the practitioners was key to the success of the work that was done together. This relationship developed over time into an equal, trusting partnership. Just being in the partnership gave the practitioners a feeling of confidence that someone was ‘on their side’, which in many cases was enough to empower the practitioners to act. Key elements that enabled this partnership were trust; a feeling of equality between us; and a balance between being independent yet being aware of my presence.



*Figure 20- Reflective Synthesis of Theme 2*

## Theme 3 - Facilitation Activities

Focus ideas

Think differently and deeper

Challenged for action



*This picture illustrates the overall way of working of the facilitator and practitioners. There are two main circles that interlock. The outer circle has a wide, multi-coloured base that depicts the multitude of thoughts and ideas swirling in the practitioner's heads that I helped them to channel into more of a focus. This moves into the inner circle where most of the 'hard' work took place – the real exploration of their impact on their practice. This would then move out into the bigger circle and actions, and then potentially into the need to focus again. The practitioner could be at any point in the painting at any time. Some only made it into the inner circle for a short time, and some spent a long time in there.*

When I met up with the practitioners for their first one-to-one meeting they had all completed reflective self-assessments of their current practice against the attributes of the REACH framework, and this provided a rich source of material for us to start to explore. After the first few meetings however we started out either following up on an issue from a previous session or talking about what they had been doing in the last few weeks, or what was coming up on their horizon. Sometimes it started with them simply having a general moan about current issues in their practice, and sometimes we started simply 'having a chat'. Throughout the study the facilitation activities all took place through this one-to-one conversation, which highlights the importance of the relationship that was illustrated in the last theme.

My intention as the facilitator in the study was to use the conceptual framework of critical companionship as a guide for the facilitation. Critical Companionship (Titchen 2000) is a very neat, very complete framework, but its' language makes it difficult for practitioners who are not familiar with facilitation or this work to get to grips with. It is also much easier to use it to analyse facilitation techniques after the intervention has occurred, than it is to use it to consciously direct the facilitator interventions during the conversation, as it is very theoretical. That said I have done a large amount of reading around the concepts in CC, so I was often aware that I had just done some 'consciousness-raising' or 'problematism'. What I was most interested with in this research study however was the role of the facilitator, more than theoretically describing how it was done. This is why the facilitation in the research is described as 'activities'.

The two most commonly used facilitation methods were questioning, and high challenge / high support. Most one-to-one meetings did not contain just one activity, as usually the issues that the practitioners talked about required multiple approaches tailored to the situation and the practitioner. I would ask the practitioner some clarifying questions to enable me to better understand the issue, and it was from these that the relevant part of the work would emerge.

This section starts with illustrating the specific facilitation methods that were used within each one-to-one conversation.

- Working with Questioning
- Using Challenge & Support

It will then move on to look at the sub-themes of theme 3 – Facilitation Activities

## **Using the Facilitation Methods**

### **Working with Questioning**

Questioning is one of the facilitation methods mentioned in Chapter 4 and is one of the facilitation strategies from Critical Companionship. It is an overarching, multi-faceted facilitation strategy that I used throughout the conversational work with the practitioners. To use questioning skilfully requires considerable practice, and although not a novice I was still developing as a facilitator, so there were times when my questioning was a bit clumsy and not very effective. However this work was concerned with understanding the role of the facilitator in helping the practitioners to learn, not about exactly how a question should be asked to have a desired effect. I had been open and honest with the practitioners from the start about my level of expertise, and we were working in a partnership, so these things were just accepted as a part of real life. If my question was clumsy or not understood, a simple apology followed by better phrasing was the usual course of action.

The practitioners saw questioning as a key intervention to assist them to think more deeply about their practice. The questioning made them consider things that they had either not consciously thought about before, or it made them think about things differently. The answers to the questions were generally felt to be already within the practitioners, but it needed the questioning to ‘surface’ or ‘pull out’ this knowledge.

“You seem to know, not the answers, but the questions to ask for me to get to find the answers myself” (CRA 5876).

Once we had started the practitioners would often continue questioning themselves further after the one-to-one meetings.



### **Example 1 – “tell me what you do”**

In this example I was asking Gwen about her plans for leading her new team. This form of questioning was focussed on something that Gwen was going to do rather than reviewing something she had already done (G1). It is an example of simple questioning, which erred on the side of support rather than challenge.

The first set of questions were simple fact finding, mainly closed questions

Tell me what you do in your current job then?

When did you move?

And how many in the team?

And they are all Band 5s? All specialist trained?

So how many are doing the course?

I then asked a key question to both test Gwen’s understanding of her new role, and to generate a topic for us to explore in more depth

So when you say ‘managing the team’, what will you be doing?

It was obvious however from her answer, and from the time that it took to give the answer, that she did not yet have a great deal of understanding of the role, so I gave her some verbal support and reassurance and then went back to a simple question requiring a factual answer.

Is your case load that much bigger?

The next question needed her to make a value judgement that required some thought,

Is that noticeably easier on your staff?

From her answer to that question my following question brought up an area of her new role that required further investigation

So you have slightly more patients and a lot more staff but they are still just as busy. Why do you think that is?

Gwen was able to draw on her existing knowledge to suggest possible reasons for this but recognised that this was one of the things she needed to find out in her new role. The final question was a broad, open question that gave her the opportunity to talk about her staff as people.

Tell me about your staff

Once Gwen was comfortable answering the factual questions again, I then pulled on something that Gwen had said earlier in our conversation and linked it to her new role, asking how she thought one might impact on the other.

How is that different viewpoint [...] that you mentioned earlier going to impact on the way you manage your staff?

I then essentially summarised Gwen's current knowledge state and asked another question designed to help her to consider her future role as a team-leader. This time instead of focussing on the new aspect of her role which she was unable to answer previously, my question was designed to help her to draw on transferrable knowledge and link that to what she does know about the role.

And how will you go about finding out about your staff, what they are interested in, want to do, career aspirations?

After this meeting the plan would have been to meet up again in a couple of weeks to revisit the questions around managing her team and see if she had been able to find anything out about the way her new team were working. In the event by the time we met up 6 weeks later Gwen had returned to a Band 5 role and changed workplace again.

The pattern of questioning in most of the examples follows this general pattern of simple 'fact-finding' questions, followed by questions to help the practitioner to think about their work, to use their existing knowledge and to generate possible actions.

### **Using Challenge and Support**

Challenge and support were overarching facilitation strategies. 'Challenge' as a word was not liked by the practitioners as it was linked in their minds with confrontation. Despite many attempts however they were unable to come up with an alternative word that they preferred, so we continued to use it. During the one-to-one meetings and in the data analysis days however they were able to identify non-confrontational examples of challenge and discuss its impact,

"The challenge may be thrown at me, but I understand now what it is and how to deal with it" (CRA 2303).

The levels of challenge and support were measured using a challenge/support grid after almost every meeting, and at the start there were occasions when the challenge was perceived as being really quite strong. It could be questioned however whether it was

the challenge that was strong, or whether it was just the intense emotional reaction by the practitioner to being enlightened about their way of practicing.

“It was like you just grabbed me and shook me and said “listen woman”. And it was like “Oh my god this is right” and I think that was the turning point for me, and it was a big turning point. And I started to reflect then and think about how I am going to do this...”  
(CRA 8580)

The change in our relationship and its slowly developing nature meant a developing depth to what the practitioners elected to share, but also a difference in how they perceived challenge. The closer relationship meant the ability to work with an increased level of challenge, but in most cases although the challenge increased, the practitioners felt that it induced less stress

“Our relationships has grown and developed on an individual level, therefore there is more trust and it feels less of a challenge and more of a support. And the words challenge and support almost become into one, because to me the challenge is almost a support, does that make sense? Because the word challenge is almost a confrontational word, and I don’t feel it is confrontational. (CRA 4416)

The level of challenge that the practitioner perceived also depended on how they were feeling at the time and whether there were other issues going on at home or work. At times the challenge I offered made the practitioner cry, but this was often unpredictable - times when I thought I was being very challenging the practitioner responded well, at other times when I didn’t think I was being particularly challenging it affected the practitioner emotionally. Towards the end of our time working together there were times when I felt as if I was unable to provide the practitioners with any ‘challenge’ any more, and I wondered if it was me that had changed or if it was the practitioners that had changed (reflective field notes).

The practitioners always rated the amount of support they got from me as 7-10 out of 10, and this support was felt even when we weren’t physically face-to-face. A number of practitioners commented that in a difficult situation they would often ask themselves “what would Caroline say to me now?” and answering that question to themselves enabled them to feel supported. They also got a feeling of support from simply being able to talk things through. A large amount of the support that the practitioners experienced derived directly from the relationship itself – it was about knowing they were supported rather than having to directly engage in ‘supportive’ interventions.

Being supportive is believed to be different from using supportive interventions (Heron, 2001). 'Being supportive' is seen as 'loving' where supportive interventions are seen as 'caring'. The 'caring' can however result in being over protective of the practitioners and result in the balance between activities that support stability and those that stimulate growth being skewed. This was illustrated during the study when on one occasion I was overcome by paternalistic feelings for the practitioners and this led to doubts about undertaking activities with them to stimulate their growth.

*This raises questions for me about the practitioners feeling empowered, taking action on that empowerment, and the implications of that for them. Ethically how much do I keep challenging [the practitioners] to challenge practice, or should I be encouraging them to tow the party line for some safety for themselves?"*

*Field Notes. June '12*

And as can be seen from the relationship theme above, it was only when there was an issue in the relationship that I actually had to consider whether my interventions might be 'non-supportive' to that individual in those particular circumstances. When the relationship was strong I never had to consciously think about whether I was in general 'being supportive'. There were however some interventions that I specifically used in order to help the practitioner to feel better about themselves.

### **Example 2 – "Someone to say it as it is"**

Direct personal challenge was generally difficult to deliver, but it often was the intervention required to move the practitioner from the hole they were stuck in. At times these holes were quite distressing for the practitioners and my overwhelming desire as a facilitator was to be 'kind', gentle and just offer advice. However the interjection of a meaningful challenge (Appendix 7B Example 2) was often what unlocked the situation, so the practitioner could move forward. In this example suggesting that the practitioner sounded 'hard done by', and a little later asking whether she had done anything to address the situation beyond 'feel sorry for herself', was enough to break the blockage and help to plan some constructive activity. When

offering this direct personal challenge I was aware that I knew the practitioner well and we were in a safe environment. This was important so as to make sure that the practitioner felt ‘challenged’ but not attacked, and it did indeed work.

In our last meeting and I was there having a whinge....and you said to me “you sound very hard done by” and it just made me think...OK get a grip...like you just make us snap out of it...[...] like you can get so into a rut and you are like, “I hate this and I don’t want to be here”, and then you just start being so angry about everything you can’t see a way out (CRA 3619)

### **Example 3 – “Getting me to do something I should have done”**

A second form of challenge occurred when I was challenging the practitioner over something they had or hadn’t done that they had agreed to. This was easier for me to offer than a direct personal challenge simply because it was less personal, although this was no guarantee that it was any less strong.

Caroline – I don’t know who else has seen these patient satisfaction surveys, but you have had them for a long time now

Melanie – Yes, I need to do something about them

Caroline – Yes, because all the while you are sitting on them doing nothing...

Melanie – Things aren’t changing

In this example this patient feedback was an essential bit of information that the ward staff needed to try to improve their practice. It was Melanie’s delay in sharing this that I challenged her on, and again it led to direct action. (Appendix 7B Example 3)

“Do you know what I did following that challenge? [...] First thing Wednesday morning I went to Audit and picked up the patient satisfaction surveys and the first job I did on Wednesday morning was I went to (Ward Band 7 & 6) [...] and I shared it with them. [...] And I kept pushing on the fact that there were some very good things in there, but there were some things we need to work on, and it was a good little session - Melanie (K10)

### **Example 4 - “I still can’t believe that I am good at nursing”**

The third example is not challenge but was instead ‘challenging’ for the practitioner to talk about. (Appendix 7B Example 4) Challenge is a provocative statement that is

designed to help the practitioner to look at themselves or their practice; finding something challenging usually means that the practitioner finds something difficult to talk about or engage with. One of the things that a lot of them had difficulty with was talking about their good practice, recognising it as good and being prepared to say it was good. For some this was more difficult than for others.

“I personally find that the information that we discuss is more challenging now than what it was, because of what I get out of it. Especially like in the last session that we had, and we ended up talking about my passion for nursing and I ended up crying. Because I feel more confident with you, because I am happy with our relationship, so I feel that I can talk to you about more things. But I find it challenging discussing these issues, so that is what I find more challenging now”. (CRA 2295)

### **Example 5 – Challenge & support – “stepping over the fence”**

This example (Appendix 7B example 5) demonstrates the way support and challenge can be intertwined in the same intervention and requires the facilitator to have an available range of facilitation skills as well as life experiences to draw on. This was the first one-to-one meeting between Bethan and me although I had facilitated a few action-learning sets for Bethan’s team in the previous 6 months, so we had met up previously and we knew a bit about each other. It was this knowledge that I was able to use to make the intentional decision that asking Bethan to compare what she did on a day-to-day basis with a team leader she had just described would be both supportive and helpful for her, and so it seemed to be.

The second part of the conversation developed on from this activity and something Bethan had said at the end of it. I picked up on this and offered Bethan quite a heavy challenge, which was using my own experiences of staff difficulties when making the transition between a Band 5 and a Band 6.

Caroline - Well a perfectly blunt statement is if you don’t want to take that management line and that leadership responsibility and all the rest of it, then you need to go back to being a Band 5.

Bethan – I realise that now Caroline, and I think that is the difficulty I have had. I thought I was being fair, and I realise I didn’t take a step back, and some people have taken advantage of it, and I have allowed that to happen to be perfectly honest with you. (B1)

This challenge was a key intervention as it allowed Bethan to articulate that this was the difficulty she had been struggling with, and it steered the direction of a large proportion of the rest of the work we did together. Identifying a lot of positive things about herself and then being the person that identified the main problem that she had, made it much easier for Bethan to both own the issue and then work to address it.

## **Facilitation Activities**

Having given some examples of the two main facilitation strategies that were used during the one to one conversations, for the remainder of this section I will be illustrating the facilitation *activities* that were used to help the practitioners learn from their practice. Each activity is titled using the practitioner's words. Some activities have a few different practice examples, where different nuances are explored; some have just one key example. These activities contained a combination of facilitation strategies, and the use of the critical companionship facilitation concepts. Within the theme of 'Facilitation Activities', there were 8 sub-themes that were highlighted by the practitioners. There is no suggestion however that these are the only activities that are possible or that these activities have to be applied in a 'tick box' fashion, but these activities were the ones that were identified by the practitioners as being the most helpful to support both them and their learning.

The sub-themes were:-

- "Solving problems"
- "Giving us options"
- "Channelling ideas"
- "Being a sounding board"
- "Pulling things apart"
- "Broadening our horizons"
- "Changing our thought processes"
- "Putting the ball back in our court"

In total these eight facilitation activities were felt to enable a change in understanding, a change in perspective, or a change in the way things were done or acted upon.

### **“Solving Problems”**

This sub-theme was about giving practical help. Although most of the one-to-one conversations tended to be closer to the emancipatory end of the continuum, there were also a few occasions when our session became an occasion for simple practical help. Working with a practitioner in a one-to-one situation it is easy to become caught up in the ‘importance’ of the emancipatory end of the facilitation continuum, but there were occasions when working in a person-centred way required us to address a practical need. This was generally to achieve something that was the current main focus for the practitioner eg. helping them to write their first annual report, helping them prepare a presentation for an interview. Although this might not be viewed as the ideal use of one-to-one time to support learning, for some of the practitioners at certain points of time it was the most important thing to do to enable them to move on. Providing practical help did not mean that learning did not occur.

### **Example 6 – “It was just so simple”**

The day before an interview Jade and I met up for a one-to-one session. Her overriding concern was her interview, and in particular her presentation.

Jade did the presentation for me, but although she had all the relevant points and facts there, the presentation was confused and I was unable to get a ‘take home’ message from it. When we sat down to talk about it Jade started to cry and said that she was not happy with it, but didn’t know how to resolve it. She said that every time she tried to make it better she just ended up adding more slides and more confusion.

We started again with a blank presentation, and by talking to Jade she was able to tell me what she thought were the key points she wanted to get across. By giving each of these key points a slide, Jade was then able to talk through the things that should be on each. Once we had done this Jade had the bones of a revised presentation which she was going to finish off by putting in the text from her other slides, some pictures and



a background. She was smiling again and felt that she now had a presentation that she was on top of, and could speak to easily without having to endlessly rehearse, because she knew about everything that was on the slides. It was her and her work, and she was not trying to remember things that were not 'part of' her. In the following meeting Jade, who had been successful at interview, described how her presentation had gone.

I was told it went really, really well. The presentation then, I put all the bits together after I left you. I read through it a couple of times and that was it. I thought I would just stress myself out if I read it anymore. Read it once more the day of the interview, that was it and it went amazing! The presentation was - it was just so simple how you could just slot it back in - exactly the same contents, just in a different way. I just felt so much more relaxed. [J8]

### **“Giving us Options”**

This sub-theme was about making suggestions or giving advice. The practitioners all identified that this work was important, but in the end it was the practitioner who had to choose what they would do. And sometimes, despite agreeing a course of action, by the time we met up again they had not done it because either it just 'didn't feel right', or they had the confidence to try out a different route, or they had simply lost motivation. This was something that I had to accept, because it was important throughout the process that the actions were the practitioners' actions they were not my actions, and also developing confidence to 'go it alone' is what will make the personal changes sustainable.

“You might suggest ideas, you might be part of that planning process, but I might decide well actually I am going to go this way instead. I am not going to go the way that you perhaps suggested, because I feel confident to try out a different way” (CRA 4372)

Thinking about what action could or should be taken often involved the questioning identified above to support the practitioner to generate their own ideas for action, but in addition I would offer suggestions of possible courses of action eg. suggesting Annie used cards for patients to write their questions on when she wasn't there so they had something to discuss when she was there (A2), suggesting that Helen offer to be the mentor for newly qualified nurses returning from maternity leave (H3). The most

important thing when suggesting options was to make sure that they were actually realistic options that were do-able for the practitioner at that moment in time.

This facilitation activity differs from the “putting the ball back in our court” activity that is referred to below, because this activity was much more about suggesting and discussing WHAT action could be taken, whereas that activity is about identifying with the practitioner HOW an agreed action could be progressed.

### **Example 7 – “Yes, I like that idea”**

Jade was taking the lead in certain aspects of a project that was being implemented on her ward (Appendix 7B example 7). One of the things she was supposed to be doing was using a questionnaire to determine the existing knowledge of staff. Following on from our conversation in our first meeting about person-centred care, and from Jade’s desire to work with this attribute I thought that Jade could use a more ‘person-centred’ way of gathering information from staff. I suggested this and we discussed the possibility of using focus groups rather than a questionnaire.

Yes I like that idea. That is much more me. I really do like that and I might suggest it to (the CNS). (J2)

The comment by Jade that ‘this is much more me’ was the one of key things that made her ‘like the idea’, but as can be seen from her comment there was still no guarantee that she would use this suggestion. Jade fed back on this experience in one of the data analysis days.

“There are a lot of things that we talk about in our meetings that have changed the way I am going about it (the project) - the questionnaire for example - I didn’t realise that it would take so long for the questionnaire to become suitable to get results from it, and we have actually had a focus group now which was quite good. [CRA 921]

### **Example 8 – “Just something on paper”**

The example from Jade above was in marked contrast to the success of the suggestion I made to Gwen, who was keen to undertake some further education around palliative care (Appendix 7B example 8). She wanted to do a module from the Palliative Care

degree programme to validate her knowledge, and I suggested that she could develop her own learning programme that might actually be more beneficial for her.

Caroline – You could start off by identifying what specific skills you need and really focus it on what you are interested in doing and work that way. You might actually cover a broader subject area that met your need, than just writing one assignment

Gwen - Yes that is true. What I might do as well is pick one of the Macmillan nurses and see if they have any thoughts of what we could improve on. What areas we could develop to help then, so that we can work better together. Not that we don't work well together now because we do, but there are some things that could be improved.  
(G4)

This intervention was not very successful, and I think that was partly due to the fact that, as she admitted, Gwen wanted the 'piece of paper' more than she felt she needed the actual learning. The other reason why the suggestion may not have been taken up was down to me as the facilitator and how I explained my suggestion. For Jade who was doing the work anyway, I suggested a different way of doing something that she was already going to do, so the change and the effort was probably much less than the effort that would have been required for Gwen. For Gwen to change from 'signing up' with the University for an existing palliative care module, to trying to work out for herself what she needed to learn, plan the learning, carry out the learning, record the learning and then attempt to jump through the Accreditation of Prior Experiential Learning hoops with the University to get it accredited was a massive difference. In addition if she signed up for the University module she would have been able to apply for study leave, whereas doing it by herself would have meant precisely that. It was just too big a difference, and at this moment in time was not going to be practical or achievable for her.

### **“Channelling ideas”**

This sub-theme was about helping the practitioners to get a focus.

Many practitioners have lots of ideas of things they would like to do; things they would like to change; or they have been asked by someone else to 'take on' a project. For many the sheer number of their ideas or the enormity of the task, in conjunction with their 'everyday' work often overwhelmed them, and they end up either going round in

circles, or giving up altogether as their ideas were just too big or too complex. This element of the work we did together featured quite heavily in the practitioners issues identified from their creative work during the data analysis, and was referred to as channelling or focussing. One practitioner described it as providing a ‘mind map’ helping her to identify what her options were. It was enabled by my knowledge of the practitioners and the context that they were working in, and therefore varied between practitioners, but it generally helped them to ‘navigate the maze’, straighten confusion and focus their ideas. Once a focus had been achieved then action could be planned.

### **Example 9 – “tackling this thing in completely the wrong way”**

The first example was about trying to help a Band 5 staff nurse effectively participate in a project that was being delivered as a pilot project at ward level, but was running in conjunction with a national organisation. Helen had been asked to ‘take the lead’ for the ward, but she was unable to describe to me what the project was about and what she could do with it (Appendix 7B example 9). The project was based around the implementation of a care bundle, but Helen was not convinced that the care bundle on which the project was based was ‘right’ so thought some of it should be changed. Her initial thoughts around the project were just too big and too complex, and this was effectively paralysing her from taking any further action, and stopped her from recognising the work she had already done. Through sitting down together and looking at the information about the whole project, Helen was able to narrow down her focus to something that she could realistically ‘take on’, bearing in mind her role as a full-time Band 5 Staff Nurse (H1)

The key actions that I took in this were trying to make her think broader around the topic, picking a focus and then narrowing down into that specific area. Knowing the context of the ward (a lot of nurses new to the speciality) I had something in mind, but wanted to encourage Helen to think for herself.

But when she just looked a bit blank I made the suggestion about assessing the nurses’ knowledge as well, and not just the patients.

Caroline – [...] Because think what you learnt the other day about nebulisers and oxygen. Are you the only person on this ward that didn't know that?

Helen – No, because I have already helped others out with that as well. A lot of us on this ward are from different medical backgrounds. Because when Ward x closed a lot of girls were redeployed here, but their backgrounds are stroke and CCU rather than respiratory, so they are not as au fait with all of this. And we have a lot of people leaving at the moment so it is a very green workforce and we do need the training.

This focus into a relevant small area freed Helen up to start thinking of practical applications, which I was then able to encourage. My purpose in doing this was to ensure that she was working with her own plan and not just implementing something I had suggested. Having helped Helen to focus from the large and complex into one small and manageable area she was then able to do the same thing with another aspect of the project and ended up with two areas of focus that she could plan for and take forward.

I think I was tackling this thing completely the wrong way. I was tackling it head on, when really it is a tool and I should be helping it. So that is a brilliant one. – Helen (H1)

### **“Being a sounding board”**

This sub-theme is about listening in a non-judgemental way.

This sub-theme considers the practical help provided by simply listening and being a ‘sounding board’ for the practitioners. Many times throughout their day to day practice the practitioners are involved in events or issues that challenge them, their way of working or their values and beliefs. When considering the context that the practitioners are working in one of the things they all found difficult was any degree of conflict or confrontation, so it is no surprise that most of these issues were about potentially difficult working relationships. The majority of practitioners will rely on family members (often spouses) to listen to their concerns as they try to work through the issue. In many cases the family member just provides a listening ear and perhaps some comments of varying helpfulness - “they listen but they don't really understand” is a common comment. Alternatively practitioners will talk to each other in the coffee room, and although many of these conversations end up as being ‘supportive’ they still

don't provide that level of reassurance that they have 'done the right thing' or what they are planning is the 'right thing'. What appears to be relevant to this sub-theme is the trusting relationship and the fact that the practitioners, although feeling that we were 'equals' in the relationship, still knew that I was a senior experienced nurse, so my perceived agreement with what they had done, or my suggestions or advice about what they could do was valued because it was 'sharing the burden'. This is picked up in other sub-themes where the practitioners felt more confident to do things because they had 'back-up'.

As the facilitator my aim was to listen to the practitioners concerns as they talked through the issue that was bothering them, and then to ask them questions that will help them to gain clarity about the issue and their actions.

#### **Example 10 – “It's been nice to voice my concerns”**

On one occasion Eve and I had to spend a few meetings considered the fact that another CNS had complained about her (F7). The complaint was that Eve - who despite being new in post was not inexperienced - was overstepping her role boundaries (Appendix 7B example 10). Eve felt that the complaint was caused by the corporate organisation of services, where the service had been designed to meet the needs of the system rather than the needs of the patient. Eve's enthusiasm and commitment to her new role had highlighted areas of deficiency in the existing service and that had made it more uncomfortable for the existing CNS, who had subsequently complained. At our meeting a few days later Eve wanted to talk about this and explained the whole situation. In total we spent 45 minutes discussing the issue.

So I came home on Friday - I have not had anyone say to me you are doing your job wrong in my whole career, no-one has really brought me down to make me feel that bad - and I felt quite deflated coming home (F7)

My questions were designed to help Eve think through the process, and to help her to rationalise what had happened and where she wanted it to end. I am also mindful that this is not support for the practitioner at all costs, but it is about helping the practitioner to really think through the implications of the event and their actions, so my questions were designed to do this.

Having thought about the initial complaint, the possible reasons behind the complaint, Eve's way of working and its impact on patients, I helped her to bring it to a 'holding space' where she could deposit her anxiety about the issue. The aim was to enable her to continue to work well in her role until the meeting between both practitioners and their line-managers would hopefully bring it to a resolution.

Caroline - So you know why you do what you do, and you are happy with what you do.

[...]

Caroline – Are you going to change anything?

Eve – Not for the time being, no. For the time being I will carry on [...] so long as I am doing right by the patients. [...]

The benefit of this intervention to the practitioner was summarised by Eve during the process review for this meeting.

Eve – I think for me it's just been nice to voice my concerns and everything today, because I have just been so stressed over the weekend. I can't stand anything like this, so it's just been helpful just to revoice it. And for you to make me feel yes, I am doing it for the right reasons. Because that is what I tell myself and then its like 'omg ....'. Its very easy to get pressurised by - not management - but other people and things that are already set up in their jobs. And I'm quite new and I'm thinking like, omg I don't want to have a hard time. [...] (F7)

### **Example 11 – “Clarified what I thought and what I had done”**

In another situation Gwen had raised concerns about a nurse who was bullying another member of staff (G3) (Appendix 7B example 11). Despite her previous experience in a more senior role she still found that the incident caused her considerable anxiety and she wanted to reassure herself that she had done the right thing.

And I did have a bit of a conversation with myself about it - should I speak to her about it, should I, in effect, break a confidence and tell the Band 7, or should I just keep quiet and see what happens. [...] I did think to myself, am I just carrying tales now? But it just really bothered me. - Gwen

In this instance knowing Gwen's experience, my approach was not so much to try to get her to think about things, as she said she had already done that, but rather to have

a discussion about the possible options she could have taken. This worked effectively for Gwen

“I think that clarified what I thought and what I had done [...]. And I think when you talk to someone outside a situation you can get things more clearly set in your mind. Whereas sometimes I think you are a bit muddled and you think 'oh god, have I done the right thing, and should I have done this'. But I think when you have talked it through with someone who is not in the situation then it clarifies everything” (G3)

### **Example 12 - “I want to make sure we get it all right”**

The third example was related to patient care rather than a relationship issue with a colleague. Melanie said that she wanted ‘advice’ from me about a patient she was involved with (K8), although when she came to talk about the patient it was apparent that she was not really in need of advice so much as a sounding board for her thoughts (Appendix 7B example 12). The management of the patient had become very much nurse-led, and it was the first time Melanie was taking accountability for this. She had recognised that in order to be person-centred there needed to be an element of ‘risk-taking’, and it was this that was causing her some disquiet.

Melanie - Half of me feels like ‘that’s his home and he needs to go back there’, and we can’t make decisions about where he goes back to, but he needs to be safe. [...]

Caroline – I don’t really have an easy answer for you. But my question is “Whose life is it?”

Melanie – It’s his life

Caroline – And I suppose it comes down to that difficult thing of what is the alternative? And is the alternative more for the patient’s benefit, or is it for the staff’s benefit?

Melanie went on to describe some of the issues that were causing her and the rest of the MDT team some concerns. My next comment was designed to be provocative in an effort to focus the discussion. This strategy worked and Melanie ‘nailed her colours to the mast’ and identified what her next step would be.

Caroline – The comfortable thing and the easy thing is to say well we will keep him here then until we can put him in a nursing home where someone else can provide all the appropriate technical care.



Because then we can tick the box, feel better and absolve ourselves of any worry.

Melanie – But it's not what they want. And that wouldn't be ticking a box because I know it would kill the patient, because he would hate to go anywhere else but home. But what I don't agree with, what I feel we can do more with, is about the home situation before he goes home. [...] So I think there is a compromise here that we need to make. (K8)

Once this decision had been reached the next part of the conversation became more about me helping Melanie to think about some of the actions she needed to take to ensure her 'risk taking' was safe and what compromises could be made. The difference between the two sections is very marked with my questions in the second section being much more about discussing options, rather than the questioning in the first section which was more about helping Melanie with her decision-making to try to reduce some of the anxiety.

### **“Pulling things apart”**

This sub theme was about the tactic of 'unpicking' practice.

'Pulling things apart' was an important feature of the work that we did together, and it was often the foundation for other interventions. In general it was about me listening, questioning and then pointing out things that they had said, or making links for them with something that they had discussed in a previous session. This helped them to identify learning that they had gained, helped them to look a bit deeper at their practice, or helped them to recognise their own good practice. One practitioner described it as 'unravelling' the event she was describing. Often when I was working with a practitioner to unpick their practice we were uncovering the values and beliefs that underpinned that practice. This was always a very different type of work to the 'doing' type of work where they were looking at concrete examples of their practice.

The questioning of values, beliefs and professionalism took many forms and was threaded throughout this aspect of the work. It often arose when the practitioners were simply 'chatting' about their day-to-day experiences, explaining about some of the things that had happened during their working day. The majority of the practitioners recognized that things were not right, but needed the space to be able to think through

their own professional responsibility and accountability in that situation, to plan the actions that they were going to take, or to talk about the actions that they had taken. In many cases we worked together as two professionals having a professional discussion, which resulted in learning for us both.

### **Example 13 – “thinking about the way I work”**

In our previous session when Annie described her normal working day it became very apparent that when she was developing this new role a few years previously she had simply taken on many tasks that were being done by the ward nurses (Appendix 7A example 13). These tasks were now viewed as things that must be done by the CNS and resulted in the ward nurses becoming dependent on her, often bleeping her to find out where she was, or wanting to know where she had been when she got back to the ward.

Annie was discussing the 'evaluating practice' attribute from the REACH framework, and we started to talk about patient feedback and how that was being gathered, and I wondered if Annie could get feedback from patients when she went round to see them, because she is slightly removed from the situation being a specialist nurse rather than one of the ward nurses. (A2). Although we had started out considering patient feedback, by picking up the subtleties and nuances in Annie's answers I was able to turn the conversation to what really mattered in Annie's practice:-

Me – So it is just to think why you are going to see that patient

Annie – I know **why** I should be going to see the patient.

Me – Ah ha! So why should you be going to see the patient?

Annie – Make sure they are OK, and that everything is OK with their care and they are progressing OK, and if there are any problems I need to address them, and if they are unhappy just to let everyone know. [...] I know that is **why** I should be doing it, but sometimes I feel as if I **have** to do it. I don't want that to sound nasty, but if I am not seen on the ward everyone wants to know where I am.

Me – So we come back to exactly the same thing as we started this meeting with - are you doing this for the person that is the patient, or are you doing it to tick the box?

Annie – I suppose if I am honest - and I will be honest - I suppose I am doing it to keep people happy on the ward.

Me – And who are you keeping happy?

Annie – The nursing staff (laughs), and not the patient, and it should be the patient shouldn't it.

This was a key intervention for Annie, as it helped her to realise that she had lost sight of her priorities in her nursing, and along with a very similar realisation in a previous session was actually the turning point in Annie's career. The most significant feature about this interaction was the honesty from Annie. Without her honesty in explaining exactly what she was doing, and why she was acting in that way, it would not have been possible to work with her to try to find a solution. This is hard, difficult work for the practitioner as it requires them to think about their own way of being, and Annie identified that she had found the session very challenging

“I think I had to think about me more today, the way I work, really stepping back and thinking about the way I work and why am I doing it that way, and why can't I do it this way”. (A2)

Enlightenment is a key first step to change, but by itself won't lead to change. It is instead the ability to see how things could be done differently that is key to making change, and that alternative view is difficult when you have been immersed in the situation for a while. Annie had been contemplating giving up nursing, finding it mundane, boring and not what she wanted, and yet despite knowing this, she had been unable to identify why, and instead thought changing jobs was her only option. Although the conversation printed here looks concise, it has of necessity been shortened, and the actual discussion took nearly 20 minutes. In the process review at the end of the session I asked Annie if I had picked up and acted on what was important to her. She thought for a long time before answering

“Yes. What is important to me is for me to look back, step back and think ‘Why am I in this post? What is my post?’ And I needed to do it as I had lost my way, and I'm starting to regain it. And the most important thing in my role, of my post, is to be the patient's advocate. To make sure the patient is doing well. And as I say I lost my way, and I am starting to look at it a different way now and putting the patient first, which it should be – go back to my nursing – no targets”. (A2)

### **Example 14 – “recognising my own learning”**

As mentioned previously I was not attempting to ‘teach’ the practitioners but helping them to identify learning that they were achieving in their everyday practice was an important part of the work, as it is too easy for things to just ‘happen’ and then the practitioner moves on to the next thing and fails to recognize that they have learnt. “Pulling things apart” was one of the ways that I achieved this with the practitioners, although there were occasions when it could almost be seen as ‘stitching them together again’

Emma was relatively new into post and was working hard to get to grips with the amount of specialist knowledge she had to learn. A large amount of this she was trying to do at home by sitting down and reading textbooks. At the start of our time together we did spend some time looking at what she had been doing in her reading, but my aim was to try to help Emma to see that she was learning all the time she was in work.

On this occasion Emma described a patient she had been to see, and the reading she had done beforehand to ensure she had the right information to give to the patient. She had also asked her Band 7 a few questions on things she was unsure of. In the event when she went to see the patient she was still asked a question she didn’t know the answer to, and although it didn’t affect the decision that the patient had to make, she identified that she needed to go back to her Band 7 to find out the answer (E7). I suggested that Emma ought to record this as learning and worked through the CPD template showing her how she could complete it (Appendix 7B example 14). In a previous session Emma had also mentioned giving a woman contraceptive advice, so I drew her attention to this, and we discussed another couple of patients who Emma had been involved with, and she also mentioned the doctor that they can refer patients on to for sexual health matters. Through this work I helped Emma to pull together a ‘package’ of learning that she had been doing around contraceptive issues, and in the first data analysis day with the practitioners Emma identified this session as important

“Had I not sat down and talked to somebody about that I would have just sort of got on with the next thing in my job and not really paid too much attention to that. I would have just moved on to something else, and not recognised my own learning as I was going along. But when I came to you and spoke to you about that, you had the objective view on it so you sort of pulled apart what I was telling

you, and it was like “Oh yes...” it was that moment of clarity. I think it was like the penny dropped and it was like “oh god yes, so that links in with that, and that linked in with that [...]” [CRA 383].

These two examples both unpick examples of everyday practice using questioning. The key difference between them is that there is challenge in example 13 that leads the practitioner to explore the values and beliefs that are underpinning their practice, whereas example 14 just explores the practitioners practice helping them to learn.

### **“Broaden our horizons”**

This sub-theme is about broadening horizons. ‘Broadening horizons’ was where I was able to suggest things the practitioners might read, people they might speak to or other sources of advice they could access eg. Taking Annie copies of documents that looked at job planning for Clinical Nurse Specialists (A3) to help her to organise her role; discussing with Helen (H3) the evidence around Magnet Hospitals, “failure to rescue”, and the Person-centred Care framework. I saw this as an essential aspect of the facilitator role, as many practitioners are relatively isolated within their clinical areas, and focussed completely on the job in hand. Unless they are undertaking additional study outside work there is often no spare time for them to identify, read and use new knowledge. This work blends with other facilitation approaches to add to the pool of knowledge of both the facilitator and the practitioner. Without this activity there is the likelihood that the same knowledge (and the same practice) will just be repeated. Evidence, sources of information, and significant other people were all recommended to the practitioners. It was up to the practitioners then to decide when or if to take this forward. As one of the practitioner’s identified

“And you don’t say ‘you must do this’, it’s like ‘have you considered this’, or ‘are you aware there is this avenue?’ So you just broaden our horizons and open up our eyes a bit more I think to what is out there and what could be done differently” [CRA 7256].

### **Example 15 – “You don’t know what is out there”**

An example of this was provided by Eve who was really frustrated at the communication skills of the Healthcare Support Workers when bathing patients with cognitive impairments (F1). Through Eve’s description of what was happening I was able to suggest someone in the Health Board that she might like to contact who could possibly advise them, as well as a contact of mine who had been doing some work around this very subject. (Appendix 7B example 15)

Caroline – I have a friend who works in Southern Ireland in an EMI unit and she has actually been doing some work around bed bathing and things like that. And how if you go about it the right way it's a nice experience. And I'm wondering if she might have anything that she can send us that would be helpful.

[...]

Caroline – And what about Y? He’s the dementia nurse isn’t he?

Eve – I don’t know, I have never seen him. Never.

Caroline – OK I will find out who he is and I will send you his details.

After the meeting I contacted my colleague and forwarded on to Eve some information about a bathing website, and also the details of the dementia CNS. In the following meeting we reviewed what had been happening since the last meeting. I asked Eve about the bathing website that I had sent her the link for, but she felt that most of it wasn’t really relevant for hospitals. However, when we returned to the issue that was of greatest concern to her, she had actually used some of the tips and techniques that she had read on the website.

Eve – [...] And because of the literature I read the other day, I tried to keep him covered as much as possible.

Caroline – That was the bathing info site?

Eve – Yes. I thought right I’ll try this technique now. Because normally they do strip the top off and things. And I was like no, while we wash his face, let’s keep him covered. Let’s use the towel to keep him covered because that way he is not going to feel cold and tense. And she (the HCSW) was like “oh OK”. But afterwards she was like “But he didn’t lash out”. “He was absolutely lovely”. And I explained it was because he felt safe, was warm and knew what was happening. I think she did take that on board yesterday. Because she did even say to the Healthcare Assistants on the late “Oh he was lovely this morning”. (F2)

During the Data Analysis Day Eve referred to this incident

“And that was the thing with Caroline and regards to networking. She said ‘well have you contacted such and such, have you discussed with so and so’. And I was like ‘no, who are they?’ And you don’t know who is out there, and there are specialists in all sorts of areas and things, and sometimes it is good to have her come back and say ‘well maybe if you made contact with so and so’” [CRA 8866]

### **Example 16 – “I didn’t realise this was so relevant”**

In addition to suggesting possible contacts or pointing the practitioners in the way of literature or resources they might find helpful to support their practice, there were times during a one-to-one conversation where I might bring in and share a theory or some external learning if I felt that it would help the practitioner.

Bethan had identified the areas that she felt she wanted to work on during the year but was struggling to work out how she could approach one of her staff members whom she felt was capable of much more than she was currently doing. She felt that the SN was lacking in confidence, but that this was due to the experiences she had been exposed to in the past. However, the last time she had spoken to the SN it had caused a bit of a rift between them, and Bethan was now apprehensive. I asked Bethan to look at the Person-centred Nursing framework to see how she could use it to frame her practice. (B2) (Appendix 7B example 16).

Showing Bethan this diagram, talking her through it and helping her to see how developing her team was an essential aspect of improving patient care, was really key to enabling her to focus on what she wanted to achieve during her year with me.

Bethan – you made me start to think about what it is I wanted to do, why I had chosen those areas, what I wanted to gain from it. And then you took me to that person-centred care diagram didn’t you, which all seemed to make it clearer

Me – Yes, that was like a penny-dropping moment

Bethan – Yes, yes it was (B2)

### **“Changing our thought processes – Why can’t we have blue grass?”**

This sub-theme was about changing the perspective of the practitioner.

I did not have the same clinical background as the practitioners, and because of this I was coming at things from the perspective of an outsider. Lacking clinical expertise in many of the specialist areas that the practitioners were working in, direct clinical teaching was not an option, and in most cases was not what the practitioners were looking for. Not knowing what was perceived as ‘normal’ practice was actually very helpful, as I couldn’t assume anything so I had to ask. When you are in the middle of things it is very difficult to see either a way out or a different way of doing things, so providing a different perspective helped the practitioner to think through alternative courses of actions and alternative meanings for things. Asking the ‘stupid question’ was therefore seen as a key intervention that created a lot of learning opportunities – either to help them to see their ‘normal’ practice differently or by raising questions that they had to take on and find the answers elsewhere.

“...It’s something that over time has got me to think differently, the thought processes used, the way you question everything, like I said earlier “why can’t we have blue grass” because that is the sort of thing that you say. You say, “Why? Why does it have to be done that way?” It’s like you say you accept the way things are done all the time – and then you come to a session with yourself and you start to question, “OK, maybe it doesn’t have to be done that way” [CRA 9017]

The idea of seeing another perspective was demonstrated in the one-to-one meetings in a variety of guises. Sometimes it was about a way of thinking, sometimes a way of doing, sometimes a way of being.

These are three examples of this intervention.

#### **Example 17 – “I have forgotten about the important things”**

In this example I was working with Annie reviewing her initial self-assessment. As part of the discussion about how she manages her practice setting, she described how she was concerned that they were failing to meet some of the service targets and what she was trying to do about this. The intervention in this example is in three parts (Appendix 7B example 5). Firstly there is a form of fact finding on my part as I



discover what normal practice is. In doing so I was also able to identify how Annie was talking about the situation, and it became very apparent to me - and eventually to her - that her focus was the practical intervention and its associated target.

Every patient that comes in has (the intervention) within those 24hrs unless it's a weekend, and then if it's a weekend some people get missed because some nurses are not trained to do it. So this has been pulled up on the fundamentals of care (audit), [...] So that is where I feel I could do better, you know. But how to go about things like that without just persistently saying, "look please you need to do this", and telling the ward sisters there "look we are failing on this target, because of this", and it's just "Oh we haven't got time, we haven't got time"

The second part involved a key question to change Annie's perspective, away from the target and onto the patient, thus humanising the whole experience.

Caroline – OK, forget the target for a minute, thinking about Mr Jones in the bed, what happens to him?

This question changed her focus from 'what can I do to meet the targets?' to "What can I do to make things better for the patient?" The change can clearly be seen in Annie's response from the first part, where she was stating matter-of-factly that the patient could go 'over 24hrs' ie. miss the target, to the second part where she suddenly recognised that a person going hungry all weekend was a problem. Once she had recognised that she was prioritising targets over people, I asked the question

Why do you think that is?

This broadened the problem out, and challenged Annie to think about how and why she had changed in her approach to nursing.

I don't know. I just think it is trying to please everybody I think, you know the managers want us to tick these boxes and get things right, and it doesn't matter what is happening in reality, as long as we are getting the figures right

The third and final part demonstrates self-reflection and revolved around another key question, which was aimed at helping Annie critically reflect on her own practice. Annie's answer, that she would find it easier to say that the team were missing targets, really highlighted to her how far she had fallen away from the very values and beliefs that were the reason she became a nurse in the first place.

Caroline – I have another question for you. If you had one of the patients on the ward you felt wasn't having his (intervention) done for an extended period of time and for some reason or other you couldn't do it, which one would you be more confident doing – going in to the (staff) room and arguing with the nurses or doctors that by not doing X, Y or Z you are not meeting this target, or going in and saying "look this patient is starving until we do something for them"

Annie – Confidence saying, I would probably say targets, which shouldn't be. I know it shouldn't be. It should be "this patient is starving", but probably saying "look we are not going to hit the target" .....yes..... um.....yes.....

This sudden awareness of where she had been had a dramatic impact on Annie and her way of being from this point forward. Annie turned from someone who was ready to give up nursing, back into a confident, assertive and happy practitioner. This session and the one following it (reported above) were incredibly challenging meetings for Annie, and it is a huge credit to her that she stuck with it and continued to work very openly and honestly with me for the remainder of the year. Her reflection on this experience was summed up during the process review.

"It's been helpful. You have made me think about my role, which I think I was - I can't word it - I wasn't losing it, but I was losing my way. I think I needed this to sort of step back and look at what I am doing. Because I think maybe I am creating too many problems for myself. The problems that I thought were really important are not that important and people can do for me, so that I can do something better, or more important or more relevant. So yes it has been very helpful actually" – Annie (A1)

As can be seen in this example, often the conversation started with one intention but ended up in a slightly different place. This ability to be flexible, to respond to the nuances in the practitioners' answers was a key facilitator attribute. The ability of the practitioner to open up about their practice and respond honestly, ensured that they gained most benefit. The whole dyadic relationship as discussed above, was dependent on trust.

### **Example 18 – "coming back with an idea I wouldn't have thought of"**

This second example is a slightly different example of providing a different perspective. One of the issues in the session had been about Emma feeling uncomfortable with expecting patients to bend themselves around the team and the

working patterns of the team. This had partly come about because of the recent frustrations of the wider team when the only available CNS had gone on a home visit. Emma had recognised that there was a problem with their way of working, and when she started to talk to me about it, this started off as a bit of a moan. Emma had been considering suggesting to the other CNS that they only undertake home visits when there were two CNSs on duty. Emma and I had a conversation about the reasons for going on home visits, and what they do when they get to the patient [E8]. (Appendix 7B example 18)

My outsider perspective enabled me to question this ‘normal’ practice. Through engaging in discussion with the practitioner, using questioning to unpick the team’s current practice, and clinical examples supplied by her to illustrate their practice, we were then able to work together to see the potential merits of the alternative suggestion. This was a very different focus to the previous work as it was more to do with an organisational change and a way of doing something differently, rather than a change in a way of being or thinking. The key intervention in this example was simple arithmetic that it was costing more to send a nurse out to take the patient’s blood than it would do for their department to buy and then loan the patient a machine so they could check their blood result themselves.

In the process review at the end of the session Emma acknowledged that it was the ability to respond with alternative suggestions that was most helpful.

“I think you could have just listened to me going on about whatever I have been going on about, bits of the service, teething problems and thinking of changing things. You could have just listened to that and not sort of thrown back any ideas. But you always come back with an idea I wouldn’t have thought about” (E8)

### **Example 19 – “flipping the coin”**

And a final example of providing a different perspective is this excerpt from Gwen (G2). I had met Gwen at the beginning of the study when she was in a secondment post as a Band 6 in a different locality. I did not meet her again for 6 weeks by which time she had returned to being a Band 5 and changed surgeries again. I used questioning to help her to identify what she had learnt from her secondment.

Caroline – So what did you learn in your 4 months?

Gwen – Not to move again! (*laughs*). To be honest, not an awful lot, not really. [...]. But no I don't think I learnt anything. Just how not to do things really, and how well things are done here in comparison with other areas, and what a good team it is here.

The key moment in this discussion was picking up on that comment about just learning “how not to do things” which for Gwen had highlighted how good her permanent team was. The key next question was

So what do you think it is that makes the team here good?

That question enabled Gwen to critically analyse her current team and identify ‘leadership’ as the key attribute that makes the difference between a good team and a bad team. I then suggested to her that this might be one of the key pieces of learning from her secondment.

The different perspective that I provided when considering her secondment enabled her to identify that she had actually learnt from what she considered to be a poor experience, and I was then able to suggest that she should record that learning so that she had something to show from her secondment. Gwen always referred to this as my ability to ‘flip the coin’ and change a negative into a positive.

“I think when you are in a situation you can't see clearly can you. Everything gets a little bit muddled, and although you might discuss it with other members that you work with, because they are in the same circle they see it probably the same way you do. But you come in then and look from the outside and ask questions, it does make us question ourselves and come to a different answer, which is probably a bit clearer than before we started.... I think that sort of helps me”.  
(CRA 7157)

### **“Throwing the ball back”**

This sub-theme was about supporting critical thinking for action.

Throughout the course of our time together a number of the practitioners identified a problem or an area of practice that they felt needed to change. Often this surfaced through the practitioner complaining about something. The key part of this activity was getting the practitioners to identify where, when and/or how they needed to take

action, and the first step in facilitating this was usually a direct question. This started the practitioner thinking and then we could work together to devise a plan.

The way that you question, because it's almost like it turns it back on us, "so you have highlighted this problem, so how are we going to fix it then". So you put the ball back in our court, so rather than just "Oh this doesn't work" it's like "OK well what are you going to do about it then?" and those sort of questions make you think, "well actually what am I going to do about it" (CRA 7238)

When trying to support the practitioner to take action it was important to work within their existing contexts and take into consideration issues such as the amount of 'power' they had, otherwise they were being set up to fail.

"So you haven't actually told me what to do, but it has prompted me to come to a solution, or to come to where I want to go. It's been, sometimes a little bit challenging, because it's easier [...] to bury your head in the sand and think, "ergh...forget about this" but you have sort of pushed it, "come on, what are you going to do about it, or how are you going to go about it, and what are your obstacles" (CRA 5912).

#### **Example 20 – "How do you transfer your way of working?"**

When I started working with Eve she was stuck in a rut and frustrated at her perceived inability to achieve anything. She felt as if she was 'just ticking over', and having been told in the past she was "too confident" she recognised that she was now holding herself back and just going in to work, doing her job, and going home. She was passionate about maintaining and improving standards of care, and had been describing to me the difficulties on the ward for the HCSW providing care for older people with a dementia. However, despite recognising that something needed to be done, she was unsure how she could do it, and had become stuck in a helpless "I'm only a Band 5" mode. (Appendix 7B example 20).

My aim was to help Eve to recognise that she could make a significant difference to practice, but in a way that would also protect her from further criticism. In our initial one-to-one conversation I sowed the seeds of being a role model and the importance

of this in changing practice. Then in the following meeting we had come back to the issue and, so my key question to her was.

How do you transfer your way of working to everyone else?

And then I reminded her about our discussions in the previous meeting about influencing others and, using the idea of the ‘Circle of Concern and the Circle of Influence’, I followed this up with another ‘how?’ to get her to actually start to think about how she was putting her thoughts into action.

Reviewing this session at the end, Eve identified how it had been helpful.

“I find it very hard to look at my practice as well, what I am doing. [...] And I have definitely picked up that influencing others is a huge thing. I go in to work and I do my own little thing and that’s it [...]. I get frustrated in work and you put a different perspective on things and throw the ball back at me and say ‘OK, so what are you going to do about it?’ And you get me thinking a lot more, rather than just coming home and having a moan. And you know that I have this thing about communication at the moment and you are like ‘right, this is how you can alter it.’ Pointing out that I am going to influence people. And I don’t often think how have I changed someone today and that sort of thing. (F2)

### **Example 21 – “What are you going to do about it?”**

Jade had been heavily involved in the idea behind a new project on her ward, but due to shift patterns she had missed some planning meetings and was feeling a little bit left out of the loop (Appendix 7B example 21). She had moved into a passive “I can’t do anything because nobody has explained it to me” mode, which may have been partly due to pressure of work. However it is this passivity that often leads to projects stalling, as individual participants or key players are unaware or unsure of their role and the delay can be terminal. The activity in this case was a direct question that required her to make a decision as to the actions she was going to take. I then followed the question up with a real problem that could interfere with her stated intentions, so that she could work through the reality of her situation to a concrete plan for action.

Caroline – OK, so what are you going to do about it?

Jade – I need to speak to (the CNS) about it. Because I have been working... I have been off sick and I was on nights and I haven’t really had a chance to speak to her.

Caroline - But you are on nights for another 3 weeks.

Jade – I know. But I have got a day shift in one of them. I have got a study day next week, and then I am sure I have got a day shift next week. [...] Yes right I need to speak with (the CNS), I might even email her later. (J2)

### **Example 22 – “At the moment the hold-up is you”**

The final example in this activity is the most directive and pivots around a strong challenge. Emma was trying to get a project off the ground, and had been pulling together a paper outlining her idea and investigating the possible benefits and constraints. This had been difficult work, and in addition there had been considerable difficulty in finding the ‘right’ person in the Health Board to take the project forward. I was aware that not much had happened with the project for a while. My focus here was to get Emma over this hump that was sitting in her way and blocking all progress. I started asking about the current position of the project, and then asked ‘why’ the project had stalled, and rather than try any persuasion I worked with what Emma told me was the reason – if she couldn’t do any work on the project at home then it had to be done in work. This set the tone for the remainder of the encounter – there was not an option of not doing it, it was simply working out a way that she *could* do it. So my first questions were very similar to previous examples where I was trying to get the practitioner to articulate a plan of action (E13) (Appendix 7A example 22). It was only when it was obvious that Emma did not have a plan, and couldn’t see her way forward to getting a plan that I felt a challenge was appropriate. I then use two strong challenges, with the first being very strong

Caroline – “The only way it is going to happen is if you pull your finger out and get on with it”.

Whilst the second, although saying basically the same thing, it is tempered by being inserted into the end of a speech that is explaining how important the work is.

Caroline – “At the moment the hold-up is you”

The strong challenge was appropriate in this instance because Emma was obviously fed up with the lack of progress despite having put in a considerable amount of work to get the project to its current state, and was now unable to see potential actions. As

discussed above, all challenge is difficult to both deliver and receive, and when it is about a lack of action, delivering the challenge without supporting the practitioner to enable the action is unfair and can lead to practitioners burning out. In this instance the practitioner and I did discuss various options to make the project achievable, before plumping for one option.

I knew that Emma was struggling with motivation to push her project forward, and this was making it doubly difficult for her to find the time to commit to finishing it. I therefore tried to inject some positivism back into things by telling her how important the project was, and also the name of another person who might be able to help take it forward. I also set a deadline for the work because I felt we were at a critical stage and the project needed some external driving. This was a very directive intervention, but in this instance I felt it was needed.

In the process review at the end of the session I told Emma that I was really tempted to tell her to let me finish it. This was the only time throughout the whole two years of field-work that I suggested I take on some of the work for the practitioners. I did this because I wanted her to understand the importance of the project, but also to help her see that it couldn't go away. In view of her previous comment that she was hoping it would disappear, it was also to give her the potential to actually withdraw should she really need to. Her refusal to let me finish the project I took as a good sign as it indicated that she was still feeling ownership.

Caroline: In actual fact what I am fighting is the desire to say "give it to me and I'll do it"

Emma: Don't do that

Caroline: No?

Emma: No don't do that. I would love you to do that, but that would sort of defeat the whole point of me learning and developing wouldn't it

Caroline: Absolutely (E13)

Having pushed Emma to get on with her project when she did send it out the email 'went viral'. She had contacted the senior nurse I suggested and had a meeting arranged, and she got her enthusiasm back to drive the project on further. In the data analysis day at the end of her time in the project when we were discussing challenge Emma acknowledged



“But that was what I needed at the time though, because I felt that that project was really dragging and I was like, “do I have to do it, nothing is really going anywhere, it’s dragging”. And you basically said to me that I was the only one holding it up, get it done. And that was exactly what I needed to hear, because I knew that, but I think I was probably just waiting for you to tell me (both laugh). So I didn’t feel like it was a criticism.” (CRA 4433)

### Reflective Synthesis of Theme 3

When revisiting the eight facilitation activities it became apparent that four of these activities were directed towards helping to maintain stability for the practitioner in their practice, and four activities were directed towards stimulating the growth of the practitioner.

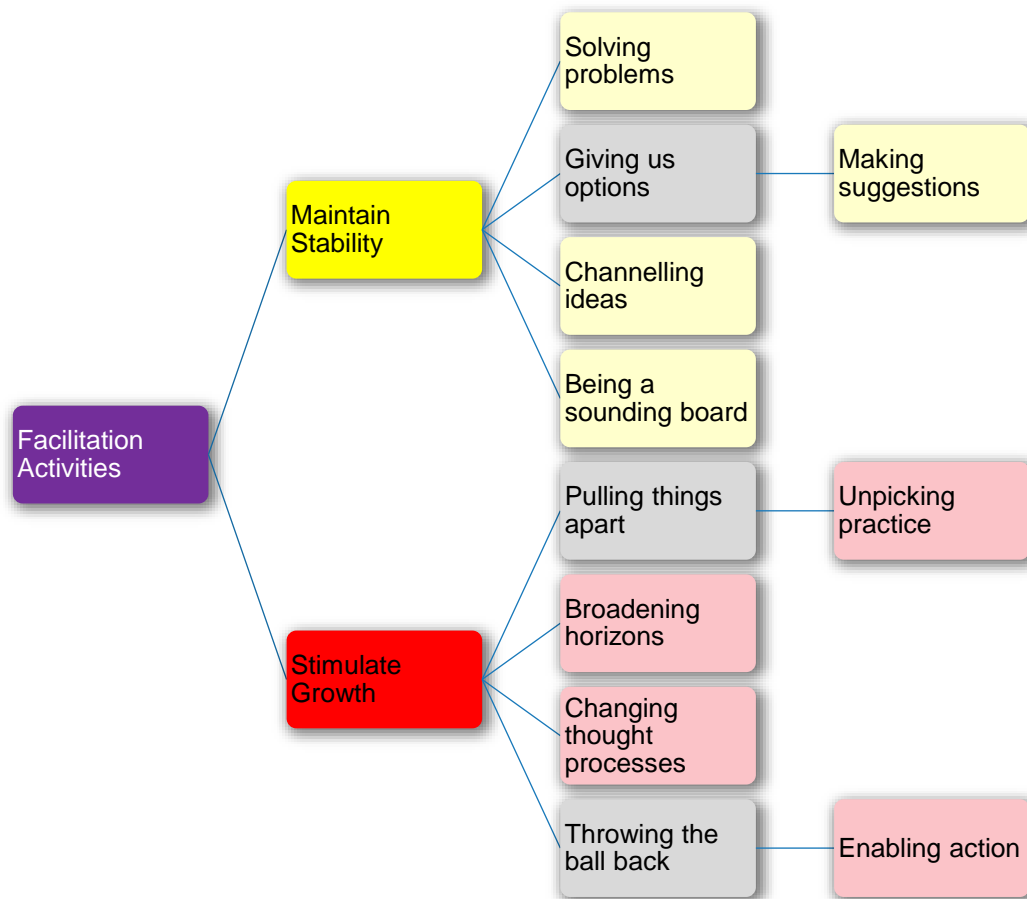


Figure 21- Reflective Synthesis of Theme 3

To enable a greater understanding of the facilitation activities to people from outside this study three of the names have been changed from the words of the practitioners to names that better describe what the activity is about (see table 4).

Table 4 - New names for three of the facilitation activities

Practitioners' Name	New Name
Solving problems	
Giving us options	= Making suggestions
Channelling ideas	
Being a sounding board	
Pulling things apart	= Unpicking practice
Broadening horizons	
Changing thought processes	
Throwing the ball back	= Enabling action

## Maintaining stability

The facilitator activities that maintained stability tended to be further toward the technical end of the facilitation continuum. The activities were those that were used to help the practitioners deal with immediate problems and issues. These were issues that were taking up their focus, times when they didn't know what to do, issues that were worrying them or causing anxiety, and issues that were preventing them from progressing with their everyday work. This group of activities were most appropriate when the practitioner's need was simply to get a handle on their current practice and was most obvious when they were entering times of turmoil and required 'support' eg. Taking on a new role; or during times of stress eg. When they were 'in trouble'.

*I feel that I just have to deal with 'what's on top' for the practitioner, and until that's done everything else is submerged. Once we had done that she was able to engage with other discussion.*

*Field Notes. Sept '12*

The activities that 'maintained stability' focused on helping the practitioner to work with their current practice and their current knowledge. They were not about rocking the boat or working with a lot of challenge, so for the practitioner and facilitator it was

a fairly 'safe' way of working where the activities were focussed on improving the efficiency of their existing routines or processes. In effect they seemed to support first-order learning (Argyris, Schon, 1996), and if used in isolation they might be expected to support the practitioner to maintain a competent level of practice rather than advance their practice.

### **Stimulating Growth**

Facilitator activities that stimulated growth were, not surprisingly, further towards the holistic end of the facilitation continuum. The activities that maintained growth tended to be used for issues where time was available to explore things at a deeper level. These included helping people to explore their practice to identify where it was going wrong, or what they were learning; sharing things with practitioners that were outside their normal practice; helping them to look and think differently about things they did in their everyday practice with a view to changing them; and working with them to identify and enable them to take action. In order to engage with these the practitioner needed to be in the right place to learn. That often meant having to work with some of the facilitation activities from the maintaining stability group first. It is only when things were stable that the practitioners were in a position to start to dig deeper and question the values and beliefs that underpinned the way they were working. The 'stimulating growth' aspect of the facilitation was about higher order learning, and was much more unsettling for the practitioner, but in the end appeared to lead to the most change and to be the longer lasting. This seems similar to double loop learning (Argyris, Schon, 1996), which is about questioning goals, assumptions and values, leading to changes in workplace behaviours and routines, and in changes to assumptions and underlying values. Practitioners who master this way of working are able to advance their practice beyond the competent level.

There is no suggestion of a hierarchy of importance between either the individual activities or between the two groups of activities, or that one group of activities has to be used before the other group. The most important thing was that the activities were used appropriately to meet the needs of the practitioner at that moment in time. What seems apparent though is that the practitioner needs to be engaged with both sets of activities to ensure that they are learning and developing. The need to support the

practitioners to develop stability was therefore tempered with the need to stimulate the practitioners to grow.

## Theme 4 - Practitioner's Outcomes



Light the central flame  
Changing my way of being  
Spread in outward growth

*This picture captures the outcomes that have originated from the study. The picture is of a tree over a flame. There are three colours in the central 'flame', the inner colour shows the centre of the flame as the changes that have occurred to them as a person; the next two layers of colours show the change spreading into them as a professional; and on outward to their practice. Without the changes in their inner cores the changes in the outer part could not have happened. The overlying tree picks up the feeling of growth among the practitioners with new leaves appearing.*

The outcomes that developed through the study were individual for each practitioner, but there was also a considerable degree of consistency between the practitioners. When looked at overall, the changes to the practitioners were on three levels, a personal level demonstrating changes to themselves as individuals; a professional level where the changes to them as an individual impacted on their professional way of being; and a practice level where the changes to their professional way of being led on to changes in their day to day practice.

The outcomes reported here have therefore been identified by the practitioners and illustrated where possible with examples of their practice from the conversations we had during the one-to-one meetings.

Within the theme of 'Outcomes' there were three sub-themes:-

- Personal Change
- Change to Professional Way of Being
- Impact on Day to Day Practice

## **Personal Changes**

The initial changes in the practitioners were personal changes. For a lot of the practitioners the work that they did over the course of the year changed their concept of themselves as people and as nurses. In some cases the change was an increase in self-belief - that they had the ability to do what they wanted to do; In others the change was an increase in self-esteem - that they understood themselves better and were comfortable with who they were. The practitioners described themselves as happier, being more self-aware, and seeing themselves in a different light. These changes led directly to a visible increase in confidence. Clarity of their own beliefs and values, and congruence between these and their day-to-day work enabled the practitioners to have a sense of direction and feel 'more at peace' with where they were and what they were doing.

Instead of just being the nurse, I am a different person when I step out. I am happier when I step out. (CRA 6469)

This has made me a different person. [...] And another thing, a big thing that it has done - I enjoy my work again - I have had people

saying “you obviously enjoy your work don’t you, you are always happy” (CRA 7550)

I think I have become more self-aware, like we said when you go into navy you have to step over the fence don’t you [...] and sometimes you do things or you say things that aren’t received very well, and I think I can take that a lot easier now. [...] (CRA 6541)

I think I have changed my behaviour, I think that is the key. And by behaviour it is the whole me, the way I am with people, the way I approach situations. The things that used to worry me don’t worry me anymore. (CRA 4394)

I don’t get as stressed about bigger things now. I think, do you know what, I can’t change that, but so long as I am doing my work to the best of my ability, and what have you, then.... (CRA 7563)

The idea of a sense of peace was referred to both directly and indirectly by a few of the practitioners, with some of them contrasting it with the feelings of frustration and turmoil that they were experiencing at the start of the project.

In the creative work on the last data analysis day Gwen illustrated this with a picture, which she described



*Figure 22- Gwen’s Creative Work during CRA 6*

It has been a bit of a roller coaster over the last year, but now I do feel that everything has just settled. The sea is fairly calm and I am in my little boat bobbing along quite happily at the moment. I just think, like the end of the day, the end of the year, the sun has gone down and I know where I am at, I am quite happy where I am at, and it is just sort of accepting I think who I am, what I am doing and

being happy about it. And knowing that it is where I want to be - at the moment (CRA 8345)

## **Change to Professional Way of Being**

The personal changes not surprisingly translated into changes in their way of being as a professional. In particular their increased confidence in themselves enabled them to be more assertive; to start challenging poor practice; to function effectively as a team leader - being confident enough not to need to be 'a friend', facilitating others to act, and sharing responsibility with their staff. The element that came out quite strongly as being different was the renewed focus on the patient as the practitioner developed clarity about their role

I think looking at the facilitating it has been very helpful, [...] it just gives you clarity on your role and what you want to do and where you want to go. And just puts you back to square one, which is all about patient care, and it just reminds you why we are doing it all (CRA 7547)

### **Outcome example 1 - "A person that will challenge bad practice"**

In order for practice to improve it is important that all staff feel enabled to challenge examples of poor practice. Jade had identified at the start of our time working together that she disliked 'confrontation', and although she felt that in principle she would always challenge poor practice, she admitted to a degree of uncertainty as to whether she would if the time came (see Context – avoiding conflict and confrontation). Part of the work that we did together to help her to overcome this was to introduce the concept of 'unconditional positive regard' (Rogers, 1983), and the importance of praise. This enabled her to reframe her way of thinking away from perceiving the feedback as confrontational. In the process review at the end of the session we considered if the session had been helpful.

Absolutely. It made me think about - if I notice bad practice - not to think about it in the negative if I tell them. Obviously think about the patient when I tell them, and think about it in a way that, it's not me disliking the person, it's me disliking what they have done. That has really, really helped me, because I have had problems with that, and if I do want to climb the ladder I am going to have to be more aware of standards and being person-centred. (J4)



Over the course of the next few weeks Jade consciously practiced these skills, and at our next meeting she recounted an example with a Bank HCSW, whom she had always perceived as ‘quite difficult’. The HCSW had asked Jade why the patient was on a food chart as they ate well. Jade said that she thanked him for noticing and congratulated him, and he looked really pleased, and Jade felt good too (J5). Jade described this work in one of the group data analysis workshops

And where I can see it as a positive as well is that I have started doing it (challenging poor practice). [...] But it’s like you said, it’s the way of dealing with it. And it’s not necessarily saying “you are a naughty person for doing that”, but rather “it’s what you have done that I don’t agree with”. It’s looking at it in that different context.[...] (CRA 2442)

And she picked out this change in herself as a key achievement.

I have developed as a person into a more confident person.[...] A person that will challenge bad practice. I always thought of it as a confrontation didn’t I. But also there is praising good practice. And you see your team develop when you do things like that. And I do that and I go home and I think, you know how they felt, and you can see the smile on their face, when you say they have done a good job. (CRA 3327)

### **Outcome example 2 - “I feel that I have stuck up for the patient”**

When she started in the research Emma had been in her post as a CNS for a few months. She had struggled initially with the feeling of having lost all her skills, and therefore having lost the ability to be a role model.

I am constantly trying to be more professional, more assertive and more - oh I don’t know what the word is - but a little bit more “raah” and a little bit less shy and not wanting to speak out. (CRA 2580)

Through the course of our work together we had looked at how Emma was developing her clinical knowledge. We had worked through a few specific issues that she had encountered with patients, both professional issues as well as identifying learning from her work. We had developed strategies to help her to teach staff on the wards, and I had facilitated and supported her developing a patient-focussed project. Throughout all of this I was encouraging her to draw upon her existing knowledge and apply that to this new role.

It took a while for me to realise that actually I had quite a lot of those building blocks in place already, and that although it was a new role I have brought those with me. And it took a while for me to realise that. That I hadn't lost the skills I had developed in the previous 9 or 10 years, it was just a matter of rejigging them (CRA 3839)

The increasing confidence that Emma developed as she was getting used to 'thinking differently' was manifest in the following incident. Emma had been asked to see a patient and had written in the notes offering an opinion that supported the patient who didn't want to take the suggested treatment that was proposed by the medical staff. She explained to me everything she had done and what she had written. (Appendix 7C Outcome example 2)

**Caroline** – How do you feel about that?

**Emma** – I am quite pleased because I feel that I have stuck up for the patient, and what is in the patient's best interest. [...] So partly I am sort of pleased, but now I think maybe I have put myself out on a limb a little bit. [...] (E11)

The above event is another example of a practitioner "using me as a sounding board" (see section above), because since she had confidently written in the notes she had begun to have doubts and she was then in need of reassurance that she had done the right thing.

### **Outcome example 3 - "I address things differently now"**

The role of line-manager is often a fine balancing act between 'protecting' staff from excess demands yet enabling them the experiences to grow and develop as professionals. This is often coupled with the need to meet audit targets, and inevitable time constraints. For many of the sisters and team leaders it is quicker and easier for them to undertake these additional activities themselves. As highlighted in other parts of this chapter although this may be effective at achieving the targets and getting the 'tick in the box' it doesn't do anything to support the development of staff and can end up with them feeling disengaged from whatever is going on at ward level.

Catrin was a Ward sister who had been working without a deputy for almost a year, and as a way of coping and ensuring that the ward was 'performing' well, she had taken on most of the additional activities herself. Some of the work we did initially

was to help her to address this, but it was only when she had to move to take charge of another ward that she was really able to start putting it into practice.

Catrin - And I do address things differently now than I would have done. [...] I mean I used to just go in at things ‘bull at a gate’ and think I’m just going to do it, because then the job will be done, and I can do another tick on the list. But then I am not doing anything for the staff, and I am not developing them, and when I go it won’t be done again. So it’s not going to achieve anything long-term. So I do think differently, and I do try and do things differently (CRA 3875)

Catrin followed this up with an example of how she was now “doing things differently.

Catrin - I think it was when we were doing those [...] staff disciplinaries. I was more concerned to get them to tell me what *they* saw the problem was, and how *they* thought they could change it, and what *we* could do to rectify the situation. Whereas before I would have said “right you did this, and this is what I want you to do”. That is what I did with the whole ward really ”this is the change you will make” and if the job wasn’t being done it was “I’ll just go and do it”. Whereas now I don’t. They do it, but now they do it because they understand now why it needs to be done (CRA 4162)

Bethan, another team leader / sister described a very similar situation, where she had allowed herself to become the person who sorted everything out. With the work we had done together this had now changed.

I FEEL a big difference in the fact that I am standing back a lot more and letting go of things, and putting the onus and the responsibility on other people. Maybe in a way I was sort of carrying people as well, and you can’t do that. Before you came along, I might have actually been burning myself out to an extent, by trying to “oh OK, I’ll go and sort it out” or whatever, but now I am sort of putting it back. And it is their responsibility to develop, to look at their own professionalism, their own accountability. (CRA 8707)

#### **Outcome example 4 - “I am autonomous and accountable for my own decisions”**

During the course of the research Melanie had cause to raise concerns about practice and care being delivered on one of the wards. She had tried to address it in a number of ways, with no real success. She was left with the decision as to whether or not to formally ‘raise her concerns’ to senior management. In our one-to-one meetings and a few phone calls we worked our way through this considering professionalism, being a patient advocate, the Code (Nursing and Midwifery Council, 2018), and her own

values and beliefs which culminated in Melanie feeling comfortable to act. After raising her concerns things got very difficult for Melanie, and I felt a degree of responsibility for having encouraged and supported her to do so, whilst I remained 'safe' and slightly removed from the unfolding situation. In one of the data analysis workshops I described these feelings to Melanie, and her response left no doubt as to the transformation that had occurred to her way of being.

Whatever decision I make I am old enough and big enough to understand that I wear my decisions on my shoulders. And if I choose to do something I do it wholeheartedly and from my whole being. And if the consequences of that - I make a decision or I challenge or highlight poor practice - if there is any comeback it comes back to me. And I know that from the word go, because I am autonomous and accountable for my own decisions. And I have never even thought twice about it actually. It never even crossed my mind that the consequences should come back on you, because it's me that is doing it. And in fact, having you there with me, enables me. You are enabling me to challenge practice. You are enabling me to be confident in making these decisions, because you provide that support. You are not lying to me and saying yes it is all going to be ok and you are doing the right thing. You are real, open and honest about it all. So it has never been an issue for me. And I have never even thought twice about blaming you. Although now you have suggested it I might! *(all laughed)* (CRA 2712)

## **Impact on Day to Day Practice**

Professionally the increased confidence and ability to think and act differently worked their way through into concrete changes to their practice, with quite a few practitioners identifying that it was only because they had made changes to their way of being that they were able to take the changes in their practice forward. They almost all identified that one of the key elements of the learning was how to think differently, to do things differently and to be more creative.

In the past I would have probably just cried and gone in the corner and thought "I can't do this". But now I sit back, I look at their side of it, and I think yes. I can understand their problem. Then I look at the politics side of it, and the management side of it, and I do try to go in the middle and try and get something out of it. And I have been trying to bend the rules a bit. - Annie (CRA 7540)

And I think that has made me think like that more, so when I am in practice now I am thinking, so does it have to be done this way? Could I do it a different way? And its just changing the thought processes. And I think it has been a gradual thing with me to get me to analyse a little differently what I do, rather than just one session where I sat down. [...] It might be like a problem in work, or something good, and then you'll say, "but on the other hand, what about this? You just always seem to see this other perspective. It's that sort of thinking that makes me think – Eve (CRA 9017)

The idea of making a difference is seen by many as only happening when the 'difference' is something large or dramatic. In an ideal world all change for the better would be applied to everyone, across the whole service at the same time. The reality however is that 'everyday' change often happens in small incremental steps. For a lot of the practitioners the changes they identified were in their own personal practice, working within their own circle of influence. This had the added outcome of relieving some of their frustration and making their own work more enjoyable. The individual changes that they made to their practice made it more person-centred, improved patient safety and disseminated good practice by teaching others.

#### **Outcome example 5 - "I have made a difference"**

Eve was able to achieve a change in the fundamental aspects of care of older adults with dementia. A key part of this was communication. Eve's method of achieving change was role modelling the practice she wanted to see and explaining her way of working to those staff members that she was able to work with on a day-to-day basis. (This work is described in more detail above).

Whereas before I was "we need to change it with the qualified". I saw myself as a Band 5 and these are Band 5 issues and above, but now I think, if I can get the healthcare support workers on board, [...] I think now that if I can just educate them that little bit more about why things happen that way; the way that we do things; and I think a lot more of them are starting to come back and say 'Oh god I have learnt loads today'. And it is about educating everyone so we are all aiming for something higher. [...] I am not going to change the whole world, but if I can get two healthcare assistants out of 20 odd to make a little bit of difference, to be more aware about something, then I have made a difference for some patients. And that

is what I have come to realise from our sessions. I am not going to get everyone on the ward to have an amazingly clean mouth, and I am not going to get everybody to do everything amazing all the time, and the things that frustrate me are going to continue, but if I can make a difference, even if I can change 1 person's practice - albeit a healthcare, a domestic staff who is not putting the cups of tea close - just little things, then I have made a difference. (CRA 7607)

### **Outcome example 6 - "Prioritise what the patient wanted from me"**

The transformational learning for Annie was the realisation that she had lost sight of her primary purpose – the patient - and was prioritising everything else ahead of them. The 'light bulb' moment described in example 17 above caused her to refocus, and from that moment on she started to flourish. The self-belief and self-esteem that she regained gave her the confidence to refocus the whole of her role.

I would say the biggest thing for me has been putting things into perspective. So right from the beginning I didn't know what I was doing basically. With my job I was trying to do everything, and I was focussing mainly on targets and not the patient. [...] And I think I lost my way, [...] I didn't want to come here and do things like this. I am a nurse, and I wasn't nursing, just tick boxing [...]. But once that switch turned, I realised then what was important in my role for the patient [...] (CRA 7209)

In her final creative piece Annie captured her overall learning from participating in the project, which she described below.

Annie – It has made a big difference to me, a big difference for me in my job satisfaction. I am happy in what I am doing. It has made a big difference to my patients because I am giving them the time that they need, that they deserve, when they want it. And I'm putting priorities in order. My day is different every day. I haven't got a set day. I go in, I look at what I have to do. If my priorities change I change them. If it's for the patient, they come first and everything else comes second. And if people say well you should be doing this, I say well no, I am going to do this first, and then I will come back to do that.

Caroline – And that has changed has it?

Annie – A lot, a lot. Because before I used to go in and try to do everything, and basically I used to go in and get everything done, and then if I had time, I used to go and see the patients. So it is a big flip round for me, a big, big flip round. [...]

## Learning how to Learn

It would be misleading to portray all the practitioners as continuously moving along an upward path towards developing their practice. For many the enthusiasm and motivation that they felt immediately after meeting up with me slowly waned, and it was only the next meeting that motivated them again. Despite this, the personal learning during the one-to-one conversations and during their period of motivation immediately afterwards built up in an incremental fashion to result in an overall change.

You come out of that meeting and you do feel really uplifted and inspired and buoyant and yes I can do x,y and z. I've got loads of good ideas, and you feel really motivated. Then you just go back and get on with work. And that motivation and that sort of buoyant feeling does last for a while. But probably by the time we have our next meeting it has waned a little bit... (CRA 4699)

This dropping off in motivation to achieve something concrete helps to illustrate the importance of personal changes. With no extrinsic motivation or reward for their learning, when the practitioner gets swallowed up by their everyday reality their enthusiasm or ability to change physical things in their practice may also decrease, but if their way of being as a person has changed and they have learnt how to learn, then this way of working becomes sustainable. This supports the idea that the learning achieved in this way is transformational and is illustrated by the practitioners below.

I think that is the idea that even after our relationship - you know the end of this year together - that I have started something that I can keep building on. And you have given me the sort of basis to do that. With the ideas of how to unpick things, how to sit and talk to somebody about it even if it's not you, than to sound off with someone else (CRA 3822)

And you left us with tools to go on with. Like I was going to take that advanced care planning forwards, remember at the beginning; or that learning from events that we were going to do; well that is still there but I needed to get to where I am now to be able to take the advanced care planning work forwards... (CRA 9162)

## Practitioner Flourishing

In this final section I present some examples of the achievements of the practitioners during their whole time in the study as well as their responses when they realised how far they had come. As some of the practitioners have identified, the changes during their time in the study were slowly incremental and therefore difficult for them to notice from day to day. It was only when they compared where they were at the end of the year with the visions that they created at the start that it really hit home.

These examples are presented in their own words using their visions that they created during our first group meeting, and the summary that they created at the last group meeting. Some practitioners were missing from the first meeting and therefore I have been unable to use these to tell their story. Some have already been used to illustrate earlier sections of this chapter.

### Eve

This was Eve's creative work that was completed at the end of her time in the study. The aim of the creative work was to summarise her achievements over the year.



*Figure 23- Eve's Creative work during CRA*

She accompanied the creative work with the following narrative,

“You have shown me how to balance between the two jobs, which are the two alternative colours. These are your little bits of insight and knowledge that you keep helping me with, and everything is flourishing. Generally I just feel so much happier, I feel I have direction and contentment rather than negativity that I felt before. These are little ideas, the little small flowers on the branch are the ideas that are almost like ideas that I'd like to change and things, but I am putting them on the back burner for the moment so that I can develop one thing at a time and focus on one thing. And one change is better than no change, and that's it...”



After Eve had shared and explained her final picture, I gave her back her original vision that she painted at the very start of her participation in the study (Appendix 7C – Eve’s Initial Vision). After seeing her initial vision again Eve’s response was

“Wow. I just wanted to be happier and that was something to work towards, and I have done it now, so that is it, reaching my goal. [...]. And I think, because it is done in stages, and you don’t write reflective accounts like this and you don’t think oh god this is what I want, and you don’t notice the change when it has happened, and it is only something like this day when you actually see something that you wrote last year that you think oh god yes I have changed. And it has happened, I was really stagnant and lost and I felt really crap last year. And this year I really feel as if I have got so much more, I am talking about doing the nurse prescribing course, loads of stuff, so I just feel so much – it’s making me think there is so much more I can do now, and I want to do things.

### **Melanie**

At the start of her time in the research Melanie created a vision of what she wanted to have achieved by the end, (Appendix 7C – Melanie’s Initial Vision) and at the end of the year I returned Melanie’s initial artwork and narrative to her and asked her what she thought. Her response was as follows,

“It is really satisfying [...]. I love it. I feel that I have achieved my hopes and - Oh I am getting emotional, don’t make me get emotional - Its good, I’m really happy. I think it has been an amazing journey for me. I think that I have got a long way to go to keep developing always, but seeing this now is - I remember being over there and doing this and feeling so confused, frustrated, under so much pressure. Not being a good wife or a mum or a nurse and it just being one big mix of confusion, and so much I wanted it to be good, I wanted to be a good specialist nurse and I wanted to be able to improve with the ultimate aim of improving patients care, and I feel like I am achieving that now. So that is why I am emotional now. There is such a long way to go, such a long way to go, but I feel like I have achieved the flexible structure, being the resource now, role modelling good practice, work-life balance, developing as a person and a practitioner professionally, helping to develop the nurses on the unit and helping to develop the service. All of those things I have managed to achieve, so thanks for making me cry!”

## Emma

Emma's initial vision was fairly generic and a bit unsure of what she really wanted to achieve. (Appendix 7C – Emma's Initial Vision). A week after finishing in the study Emma sent me an email. This was quite unsolicited, and she has since given permission for it to be used in the research.

"I think if I'm honest I went into this study thinking that you may help me learn how to be a specialist nurse or show me how to be one, and you have. But not in the way I'd imagined. It hasn't been handed to me on a platter. You've shown me how to learn it for myself, develop myself. This has made it so much more valuable and a valid achievement. Without you, without this study, I would still have been a specialist nurse but with this learning and almost nurturing I think I've unfolded into someone who wants a little more, expects a little more, strives for a little more and thinks that she may just get it!

I thought I was a reflective practitioner before - I would think how things made me feel, my colleagues, my patients and to some degree would think how I could have improved on a situation. But now I'm more person centred. I think while I'm doing. I think about the service I'm giving, and what is really important to the patients, and to me. I want to feel like I'm a good nurse and what I'm doing is the best I can offer. I've upped my game. I think about the whole picture with the patient in the middle.

It's so hard to pin point what's changed in me. I wasn't an unthinking nurse in the first place, but I really do think that being 'heard' by you has made me feel valuable - that what I think and feel is important. When a person feels like that they can grow. I guess the development in me was always there and I must have wanted to develop, but you have unfolded me. Shown me how. Made me realise what's important. Why things happen, and that I can make changes - big changes. I needed direction, needed to feel that I was useful and could make a difference. You showed me that. By talking, listening, discussing, by asking the stupid questions you got me thinking and wanting. You got me realising I can not only be a good nurse, but also take it further and achieve things. I hope I'm going to take this learning/ new way of thinking and continue it myself. You've shown me that through just having time to discuss things, sometimes nothing important can lead to amazing things. Then those things lead on to more amazing things. My motivation then impacts on others and before you know it things start to get exciting again, and you know why you're a nurse".

## **Possible Negative Outcomes**

As with any change there will always be some negative outcomes as practitioners strive to get to grips with learning in a different way. In this instance I asked the practitioners what they had liked least about participating in the study.

### **Outcome example 7 - “Living in a parallel universe”**

Melanie suggested that she found most difficult the ‘feeling like you are living and working in a parallel universe to everyone else’, because of the feelings of enthusiasm and motivation that she now had, and also that she was now ‘constantly challenging my practice, and the practice of others and the service we are providing’ (Appendix 7C Outcome example 7). This does have implications for the practitioner as they were working with me as an individual, and as the only person in their workplace. Whilst enthusiasm and motivation can be contagious, if it turns into evangelicalism they may inadvertently alienate their colleagues and have the opposite effect. In addition, the constant questioning of their own and others practice can, as Melanie identified, ‘make you go a little bit crazy’. This suggests that there should not be a limit on the number of ‘one-to-one conversations’ that a practitioner can have with a facilitator, but rather still being available to support them when necessary. The evidence from this study would suggest that over time the practitioners reduce the frequency of their one-to-one conversations themselves.

### **Outcome example 8 - “Proving to others”**

I could see that the practitioners were changing during their time in the study, and I knew that there were positive outcomes from these changes, but the learning that occurred tended to be transformational learning rather than the learning of facts. Despite being able to talk about the changes to themselves and their practice, and most of the practitioners seeing the relevance or importance of gathering written evidence of these changes, all the practitioners found this aspect very difficult. Despite most of them wanting a ‘nice portfolio’ at the end of the year, this was the one thing that most of them felt they didn’t accomplish. The reasons for this were very similar and mostly

related to the time factor, as this was an element of their work that they would have to do in their own time. There were also strong feelings that they were writing this evidence for someone else's benefit and not their own.

To me - and I am going to be blatantly honest - it's another bloody paperwork exercise. I have gone out, I have done the reading, I don't need to write about it as well. I know it is evidence [...] and it is just an extra five or ten minutes. I know for all the right reasons I need the evidence in my file, and you have told me before that I will realise then in 12 months how far I have come, and the differences I have made and things. But it is actually just the mind-set of "I'll do it later" and I never do. You know, I will do the actions necessary to progress, but when it comes to actually writing and collating the evidence for it, it just goes. It doesn't take priority, sorry. That is the blunt reason that I don't do it. [CRA 7744]

This may have been simply the way they were interpreting 'evidence'. The majority of the practitioners said they were putting the things that they were doing into their portfolios – evidence from meetings, copies of forms they devised, clinics they run etc

I have got some evidence. I have got a portfolio anyway. And you told me to get evidence - you said to ring a patient and ask for feedback, which I did - I was cringing inside doing it. I thought I have never had to do this before. But I have had a really nice letter back, and that is in my portfolio. These people had said how I have made a difference and what not. [...] And we are starting the new work on (x) so I have kept copies of this so I can collate evidence of **things**, but as for sitting down and doing reflective pieces and things, I have not really done them. (CRA 9286)

We have actually had a focus group now, which was quite good. So that little change - and I have got that evidence now, because I have got the tape. So there are little things that I can show, but in myself I have got nothing to show I have changed, apart from my feelings that are inside. But I suppose reflection would be a way that I could (CRA 921)

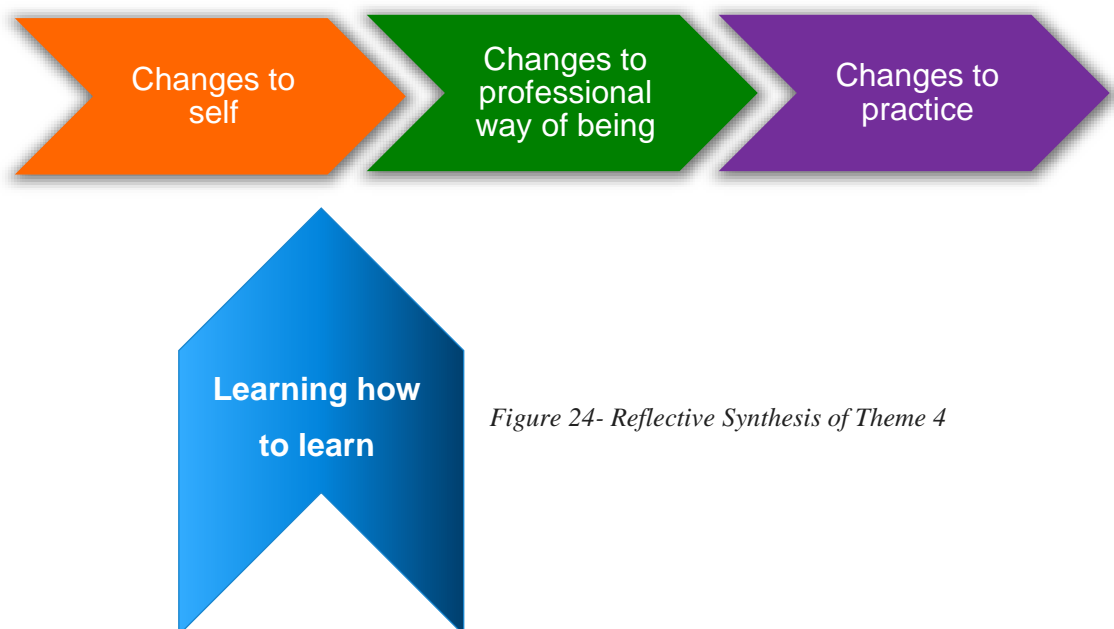
Very few practitioners were putting reflective writing demonstrating their learning into their portfolios. This was one area where I think that the fact the practitioners were not undertaking academic courses really made a difference, both to the practitioners and to me as their facilitator – there was no extrinsic motivation for them to keep written, reflective evidence of their learning, and I didn't feel that I could 'require' them to produce it - although I did keep suggesting that they did. For the few that were doing it, they kept their portfolios private and certainly never shared them.

Because I was writing records about each of our one-to-one meetings I shared these with the practitioner concerned, and they found these useful in helping to identify the actions they agreed to undertake and in demonstrating their growth over time.

Well the sessions are evidence, because just reading through the notes that you have written about our meetings is evidence to me that I have developed massively in the last few months we have been working together. In my thought processes, the way that I deal with things, my ability to cope with stress, my confidence - all of those things you can see through the discussions that we have had (CRA 858)

### **Reflective Synthesis of Theme 4**

What is immediately obvious is the change to the practitioners as people, the way they think about themselves and the way they now believe that they can make a difference. They now have clarity about their professional roles, and this has led to a change in their way of being as professionals. The change to themselves and their professional way of being has led to them changing their practice, in particular the practice that focuses on their patients. They have also learned how to learn which suggests these changes may be sustainable.



*Figure 24- Reflective Synthesis of Theme 4*

## **A Professional Learning Partnership**

The findings identified throughout this chapter have been synthesised into a model that captures the role of the facilitator in facilitating professional learning through work. This model has been named a Professional Learning Partnership.

The theme of context has been interpreted as being made up of the people and relationships that exist in work, and the practitioner's work/life balance. These impact on the commitment of the nurse to their work and their learning; how safe the nurse feels in work; and how much the nurse feels able to act.

Facilitating a nurse to learn in work requires a safe space that has been set aside for having a professional conversation.

The theme of relationship has been interpreted as a nurse working with a facilitator in a partnership that is trusting; where there is no sense of hierarchy; where the nurse is encouraged to be independent; and the facilitator remains present with the nurse.

The theme of facilitation activities has been interpreted by identifying that the eight key facilitation activities are split into two main groups. Four of the activities help the nurse maintain stability in their work, and the other four activities help the nurse to grow.

A trusting partnership, maintaining stability and stimulating growth are presented as three parts of a facilitation triad, indicating their key importance to each other.

The outcomes of the facilitation activities begin with the personal and transformational changes that have occurred in the nurse. These personal changes impact on their professional way of being, and this leads to change in the way they practice. The potential for sustainability comes from the nurse having learned how to learn.

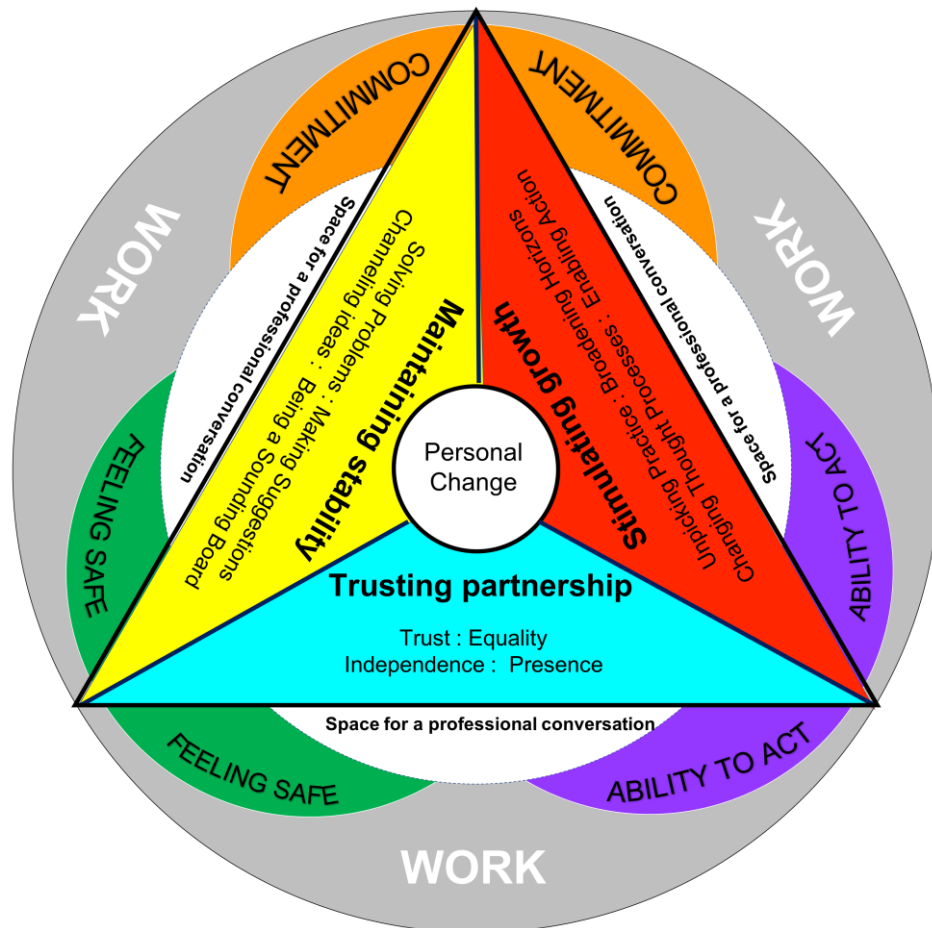


Figure 25 – A model to demonstrate the role of the facilitator in work-based learning

### The Structure and Appearance of the Model

The components in the model are closely inter-related, and the colouring of the model is an integral part of it and helps to define that interrelatedness. The elements in the facilitation triad are the main elements in the model as they reflect the role of the facilitator - trusting partnership, maintaining stability, stimulating growth. These are coloured in the three primary colours. This emphasises the importance of each element to the facilitation triad.

The learner that interacts with the facilitator is made up of three interlocking circles – commitment, feeling safe, ability to act. The positioning of these three circles is relevant. Although not seen in the model as a whole, the interlocking of these circles represents how each element in the learner impacts on the other.

Between the three circles and the facilitation triad is a space. This space is a communicative space where the facilitator and the learner interact.

The grey circle represents the work context that the whole of the model sits within.

## **Summary**

The findings that have been reported in this chapter are based on four main themes and 19 sub-themes that were identified collaboratively with the practitioners during creative reflective data analysis workshops. These themes and sub-themes have been illustrated with examples from the one-to-one sessions where the practitioners worked with the facilitator. A reflective synthesis of each theme has helped to pull out its key features. From these syntheses a model of the role of the facilitator in work-based learning has been developed. We have called this model a Professional Learning Partnership.

This model positions facilitation as occurring in a work context. The facilitation occurs in a one-to-one relationship with a practitioner whose commitment to work and learning, how safe they feel, and their ability to act is all influenced by their work context. A space is created for a professional conversation to take place. Within this safe space the facilitator and learner interact. The triad that enables effective facilitation of work-based learning is situated in this space. This triad is made up of the trusting partnership, the facilitator activities that maintain stability, and the facilitator activities that stimulate growth. Placed centrally in the triad are the outcomes of the learning, which are about changes to self, a changed way of being, and professional growth.

The next chapter will discuss the findings and the main elements that make up the model.



# **Chapter 6 - Discussion**

## **Introduction**

The previous chapter outlined the findings from the research that were developed through 4 main themes and 19 sub-themes. The themes and sub-themes were illustrated with examples from the 1:1 sessions, and each theme was then synthesised to pull out the key features. From this a model of a Professional Learning Partnership has been developed that contains our shared understanding of the role of the facilitator in work-based learning (Fig.25 p204) and meets the overall aim of the research.

In this chapter I intend to unpick the model and discuss it in the light of the existing literature. I aim to show how the shared understanding that is held within the model supports my claim that it adds new knowledge to the facilitation of work-based learning.

## **A Professional Learning Partnership**

The understanding of the role of the facilitator that has been developed through this study has been synthesised into a model for a Professional Learning Partnership (PLP). There are four main elements to this model. Firstly, the practitioner, secondly a communicative space, thirdly the facilitator and fourthly the outcomes.

This study was operationalized through a facilitator working one-to-one with a practitioner. It has been suggested that in order to promote work-based learning the facilitator needs to be working at operational level rather than engaging individual staff (Grealish et al., 2015). I contend however that without having engaged individual staff and understanding work-based learning from the perspective of the facilitator and the practitioners engaged in it, then the form of work-based learning that is promoted may not be fit for purpose and will end up being imposed rather than embraced. The challenge that is evident from this study is the fact that in everyday learning through work there is no guiding framework for the practitioners or any form of an end assessment. The REACH framework set out to address these issues by providing a

structure. Although the practitioners started out following learning contracts developed from their REACH self-assessments they very soon moved away from them, and moved into working with problems that directly related to them and their current everyday practice. This working in the present requires facilitators who are able to be supremely flexible. The Professional Learning Partnership is a new model for facilitating this type of work-based learning. It holds within it some of the key features of Active Learning ie. critical dialogue, and intentional action as doing things differently. (Dewing 2010). However its strength is its simplicity. I believe that this model can be used to help both the practitioner and the facilitator to understand the process of learning through work and guide their learning.

## **The Practitioner**

All the practitioners identified things about ‘the system’, their line-managers, their colleagues, and their families/home lives that impacted on them either positively or negatively, and similar contextual issues have been found in other studies (Tuckett et al., 2015). In this study I have been working with practitioners as individuals in a variety of different contexts, and learners are known to be shaped by their context (Hager, 2008). It is the practitioner as a person who participates in the learning partnership, so rather than focus on the context I have chosen to focus on the way in which this context affected the practitioner personally. From the findings it can be seen that the context impacts on the practitioner by influencing her commitment to her job and her learning; influencing how safe she feels in work; and influencing how much she feels she has the ability to act. Each of these elements can be seen as a continuum. The actual positioning of the practitioner on each of these continuums can vary enormously, but they all still have relevance to the practitioner’s learning and to the way the facilitator will work with the practitioner.

## **Feeling Safe**

The need to feel safe in work is key to being able to function effectively (Brown, McCormack, 2016). The evidence from this study suggests that it is the relationships with and between managers and colleagues that are the greatest contributor to how safe

nurses feel in work, although a perceived lack of clinical competence can also result in feeling 'unsafe'. The results of feeling unsafe in work are significant, with nurses unwilling to challenge poor practice or even to give unsolicited advice to colleagues. They are reluctant to suggest changes to practice in case they open 'cans of worms', raising concerns led to both perceived and actual threats, and nurses were reprimanded if certain activities were not completed. For some nurses this can end up with their whole practice being skewed to prioritise the work that 'got them into trouble' when it wasn't done (usually targets or audits). Although all the practitioners in the study identified events from their practice that would fit into definitions of horizontal violence (Purpora, Blegen & Stotts, 2012), they all seemed to accept this as just being part of 'life', and so consequently dealt with it by simply avoiding the practice that caused it. Accepting these behaviours and practices as normal can become self-perpetuating, with evidence to suggest that the more nurses considered themselves to be an oppressed group and 'only a nurse', the more the horizontal violence between them increased (Purpora, Blegen & Stotts, 2012, Dumont et al., 2012). It has been suggested that horizontal violence from colleagues is a nursing problem, rather than specifically an organisational problem (Myers et al., 2016), however this study suggests that the feelings of being unsafe were wider than just horizontal violence from colleagues, and were more to do with overarching organisational culture (Francis, 2013).

These findings are significant for the organisation because of the impact that they have on individual nurses and the potential impact on patients. A reluctance to challenge or even offer advice to colleagues because of the passive aggressive or overtly aggressive behaviour could be seen as colluding in poor care standards (Francis, 2013). Relationships are identified as being key to decisions whether or not staff remain in a job (Barron, West & Reeves, 2007) which has implications when there is already a shortage of staff. And whilst feeling that they lack clinical competence may be because 'the more you know the more you realise that you don't know' (From et al., 2013) it could also be because staff in new roles need help to realise that their existing knowledge is transferrable, which was something they were not getting. Added to all this is the evidence that this type of culture affects patient outcomes as well

(McNamara, Roat & Kemper, 2012) something that was picked up by one of the participants in the study.

## **Ability to Act**

In everyday life being autonomous is about being mature enough to make decisions for yourself. When at home the women in this study had responsibilities and made day-to-day decisions about household activities and finances, influencing and directing the behaviours within their family. Once in work however their autonomy tended to disappear. A lack of autonomy includes the fact that working as a staff nurse in a nursing team means that you are reliant on someone else to allow you time to learn, someone else to allocate you shifts that enable you to be present in order to participate, someone else to allocate any learning opportunities, and ultimately someone else to give you permission before you can do something. The ‘someone else’ for most nurses was their line-manager, and because of this the closer the nurses worked to their line-managers the more important it was that the manager was ‘interested’ in them. The lack of control over their own time that affected the ability of staff nurses to attend things was picked up by Maben et al (2018) when evaluating Schwartz Centre Rounds in England. This was similar to a finding in a study by Wilkinson & Hayward (2017) when exploring Band 5 nurses perceptions and experiences of professional development. Whilst some line-managers worked hard to involve their staff and ensured that nurses were given time, space and learning opportunities, others did not. Not being there because you are on a day off or being there but unable to participate because you were ‘in the numbers’ meant that staff nurses were not routinely involved in decision-making. This is not the case for more senior nurses whose greater autonomy enables them to pre-plan their work schedules to take account of learning events and also have less of a journey to get permission to act, although they may still be prevented from participating in decision-making. Not being allowed to participate in decision-making is an important feature in feeling psychologically harassed (Fornés et al., 2011), and is recognised as a form of oppression (Freire, 1996). Nurses who feel psychologically harassed are more likely to withdraw, and demonstrate apathy, conformity and fatigue as their intrinsic motivation decreases (Ryan, Deci, 2000). These feelings were certainly reported by

the practitioners prior to them joining the study, and compliant behaviour and apathy was also demonstrated by some practitioners in response to being told what to do or being stopped doing something by their line managers. This apathy and withdrawal may go some way to understand why the lack of ability to act was not always something imposed on the practitioners. Learned helplessness is something that many nurses experience when they are not involved in decision-making (Brown & McCormack 2011). Self-imposed restrictions such as feeling a lack of legitimacy because 'I'm only a Band 5/6/7' or being 'the new girl'. This is similar to findings in a study by Cardiff (2014) who identified that working with directive leadership in an area that focussed on tasks tended to lead to nurses who were passive learners.

## **Commitment to the job**

The theory of self-determination (TSD) describes three psychological needs that must be met in order for work to be motivating (Ryan, Deci, 2000). These needs are belonging to a group and mutual respect (relatedness); having freedom to choose and use initiative (autonomy); feeling productive and obtaining desired results (competence). Understanding the work context in the light of this theory enables an understanding of why some practitioners had lost their motivation for their jobs. What appeared to be important however was that they retained a commitment to nursing. This wider commitment provided the intrinsic motivation that propelled them to learn. This motivation could vary between a somewhat ambivalent having "nothing to lose", to being so committed that they became exhausted by the amount of effort they put into their learning.

Nurses who are learning 'for themselves' ie. not undertaking an academic course, want to focus on things they perceive as relevant. Their priorities, interests, and needs change as issues in their work emerge and evolve. The need to 'prove' to someone else that they had learnt was not high on their priority list. This reluctance to produce written reflective work even when it will be part of an assessed portfolio has been noted before (Esterhuizen, Freshwater, 2008, Sobiechowska, Maisch, 2007). Manley & Titchen (2016) found a similar thing in a study they completed with Consultant Nurses. They attributed the fact that portfolios were not developed

(even though it was an expectation) to the lack of support from critical companions, however the evidence from this study would suggest that time and willingness may have been a bigger factor. Nesbit (2012) is more in keeping with the findings from this study, arguing

“The use of a reflective journal may present as an unlikely activity for a busy leader who already struggles to find the time to carry out reflective analysis of events experienced, let alone engage in a disciplined approach to journal writing” (Nesbit, 2012 p212)

The ‘expectation’ that nurses will do learning related work in their own time impacts on a nurse’s home and family life. Unruh et al (2016) identified that job demands directly lead to work-family conflict but they didn’t specifically consider the need to do learning at home among the work characteristics. Even without the extra learning the practitioners’ job demands meant that they were regularly prioritising their work over their family time. When their job is already causing work-family conflict then adding an expectation for more to be done at home is unrealistic, and the practitioners in this study had the autonomy to decide this for themselves. Whilst they were committed to nursing, committed to learning, and they did some of their reading, thinking and planning at home, the motivation to spend time evidencing that learning on paper was not there because it had little or no perceived gain<sup>5</sup>. The study therefore raises a question about whose benefit is being served by the widespread idea that all learning needs to be documented to ‘prove’ it has been done.

“I have spent my own time doing the work, why do I have to spend more of my own time writing it down so that I can prove to someone else that I have done it? *I* know that I have learnt.” (Eve)

It is also suggested that reflective strategies are designed to assist learners to gain accreditation for their learning, rather than supporting them to generate new knowledge (Evans et al., 2010). This raises the obvious answer that if the learning is taking place outside an academic course then there should be no requirement to demonstrate the achievement of outcomes in writing. It could therefore be suggested

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<sup>5</sup> The fieldwork for this study took place before the introduction of the Nursing and Midwifery Council revised model of revalidation that requires some written reflection.

that the need for reflective writing is something that has become an accepted ‘norm’ and should be challenged. This conversation is starting (Ramage 2014), and this study adds to that debate.

## **A Communicative Space**

Within the model for a professional learning partnership there is a ‘space for a professional conversation’. This space is physically an allocation of time in which the majority of the interaction between the practitioner and the facilitator occurred. Physically achieving this space was easier for the practitioners who managed their own time, but for staff nurses it often had to be taken before or after a shift and then the time claimed back. It also highlights the need for nurses to be afforded protected time for learning in work. There is a real dissonance in the requirement for nurses to maintain their knowledge and skills through life-long learning, and the lack of provision for time to undertake this learning. Having to undertake this type of activity in your own time is an issue even with formal work-based learning (Ramage 2014). A communicative space is more than physical time out of the clinical area however. It has been described as a ‘psychologically safe space’ (Brown, McCormack, 2011) where staff met together for facilitated reflection. Whilst Brown and McCormack (2011) were working with a whole ward in an attempt to change the culture, the same idea of ‘safe’ space was created for the professional conversations that occurred in this study.

A professional one-to-one conversation as a vehicle for the Professional Learning Partnership was important. The idea of talking as a teacher is not new, but the intervention in this study was not the ‘talking to’ that is associated with imparting knowledge from one person to another, but rather the idea of having a two-way person-to-person ‘talking with’ conversation. A learning conversation approach led by someone with subject and facilitation expertise has been shown to recognise and expand a learners knowledge and ‘put it to work’(Evans et al., 2010 p249) and the process of having a conversation with someone is believed to help people feel valued, that their thoughts and ideas are worth considering, and that they do have something worthwhile to say. Having a conversation also implies that what we were working with

was everyday practice. This again makes the professional learning partnership different to clinical supervision where because salient, unusual incidents are more easily remembered than everyday behaviour, clinical supervision tends to deal with more unusual rather than everyday events (Eraut, 2004). Talking to someone else about your thoughts and ideas can also help to clarify them, and there were many times in the study when the practitioners commented along those lines.

“Yes, now I have said it to you I know what I should do. [...] But it is not until I say it to you that it sort of clicks into place as we are talking... - Emma

Nursing is a ‘human’ occupation and as such the importance of talking to each other as a way of facilitating learning is very relevant. In the clinical supervision literature there is a lot of space taken up discussing the importance of not confusing the personal and the professional (Yegdich, 1998), but at the same time there is other literature talking about the need for a nurse to know and understand themselves (McCance, McCormack, 2017). In trying to determine an appropriate focus for learning there is a danger that we are inadvertently encouraging the practitioner to play two parts – one professional and one personal. The aim in this research was professional learning from a person-centred perspective – facilitating the practitioner to be authentic and to bring themselves into their professional nursing practice, whilst at the same time developing themselves and their practice - so to try to separate the personal and the professional is inappropriate. This study suggests that a practitioner’s life outside work has an enormous impact on their ability to learn when they are in work, whether that is simply because of a time issue, or because their focus is elsewhere. Whilst not wanting to get involved in counselling, understanding the practitioners as people is essential if they are to be effectively facilitated to learn. It seems that it is not the exclusion of the person or their personal life from the discussion that is important, but rather recognising if or when they might benefit from an external professional intervention for a personal issue. In this study it is recognised that although some practitioners had ‘issues’, the majority of practitioners just wanted to learn and develop personally and professionally, and this was about working together to identify how that could be done. Examining all the one-to-one conversations there were occasions when a practitioner’s personal life was really relevant to their ability to learn and taking that into consideration was an integral part of working with the practitioner as a whole person.



My study therefore recognises the importance of working with practitioners as whole people, and facilitators in professional learning partnerships need to understand the importance of not trying to remove the person from the professional practitioner.

## **The Facilitation Triad**

The facilitation triad consists of a trusting partnership, activities to maintain stability, and activities to stimulate growth. The triad enables both understanding and action, and enables practitioners to learn through building on their current understanding of their work, as well as challenging them to consider their beliefs, assumptions and judgements (Mezirow 2000).

Heron identified six interventions that he used initially in counselling, although he later expanded their use for any 'helping' relationship. He describes the interventions as the 'six basic kinds of intention the counsellor can have in serving his client' (Heron, 1986 p12), and there is a degree of similarity between some of his interventions and some of the facilitation activities identified in this study. Of the six interventions five were used regularly (with the caveat of the prescriptive interventions mentioned below) as tools to help the facilitator in the activities. These tools were informative, catalytic, supportive, confronting and the consultative end of the prescriptive interventions. The one tool that was not intentionally used was the cathartic interventions. These involve a greater degree of 'personal' work than was felt appropriate in this learning partnership. At first sight this would appear to contradict the assertion above that the model of a professional learning partnership is about ensuring that the nurse as a whole person is involved in their learning. Heron (1986) describes cathartic interventions as facilitating the client to discharge painful emotion and undischarged distress that is disabling and distorting their behaviour. He also makes explicit the need to have an agreement with the client so that it is not 'done to them'. Heron explains that this work is about working with the client through denials and defences. Whilst it is appropriate to stay with and support the practitioner who might become upset during a one-to one session, I believe that is different than actively trying to extract that emotion from a practitioner. This is where the idea of setting boundaries at the start of a facilitative

learning partnership, and recognising that this relationship is not designed for counselling is important (Williams, 2012a, Williams, 2012b).

## **A Trusting Partnership**

There is longstanding recognition of the importance of the interpersonal relationship between a practitioner and facilitator (Rogers, 1983, Heron, 2001). The relationship is also at the core of the Critical Companionship framework and Titchen (2000) suggests that it involves a carefully negotiated partnership that creates equality between the practitioners and the facilitator. The relationship in this study was also perceived as a partnership but rather than being ‘carefully negotiated’ as suggested by Titchen (2000), it was something that evolved over time and was related to the facilitator being authentic and demonstrating an empathic understanding of the learner (Rogers, 1983, Heron, 2001). The willingness of practitioners to engage in a learning relationship was firstly due to a feeling that they could ‘get on’ with their proposed facilitator, and secondly that they would get something out of the relationship. It is suggested therefore that practitioners should be able to choose who they engage with to support their learning (Skår, 2010).

## **Trust and Equality**

The key element in any relationship is the trust that is generated between those involved, and this is even more important when developing a learning partnership (Newton et al., 2015). As the trust grows so the ability to be more open and honest grows (Hauer et al., 2014). The relationship that the practitioners had with the facilitator was felt to be a very different relationship to the one they could have with their line manager (Johns, 2001, Kelly, Simpson & Brown, 2002), although Cardiff (2014) suggests that someone who is more of a ‘leader’ than a ‘manager’ may well be in a good position to support the learning of staff. I would concur with that view as far as it relates to the ‘leader’ being able to create the safe environment, be interested in their staff, and enable them to participate in learning activities. However I believe that it is the position of the facilitator outside the working hierarchy that enables the required level of trust to develop. This trust is important to enable the participants to feel safe enough to talk about their current practice and the beliefs and values that

underpin that practice. The need for openness and honesty is essential for a meaningful learning relationship, and it has to be questioned how much that could occur when the facilitator also has a 'supervision' element over the practitioner. Cardiff himself goes on to state that a formal supervision relationship is likely to inhibit rather than encourage learning in nurses who do not feel safe (Cardiff 2014). It is important to note that the learning partnership is not about practitioners 'exposing their practice to scrutiny' which through its language implies something intrusive or confessional.

As the relationship developed so did the feeling of equality, being likened to moving from a parent/child relationship to an adult/adult partnership. People who work together do not have to have equal skills in order to feel that they are equal partners. In fact many partnerships work best when the individuals have complementary skills. Although there was equality in the relationship, the practitioners were happy to recognise my experience and expertise for providing them with reassurance and relieving their anxiety when they had done something that they were unsure about. This suggests that a practitioner should work with someone who can add things to their practice that they haven't got themselves and adds further weight to the idea that a professional learning partnership is not with someone in an identical situation. Differences were also apparent in my lack of clinical expertise in their areas, but this was not perceived to be detrimental to the work that we did together.

### **Independence and Presence**

The second part of the Trusting Partnership involved the balance between presence and independence. Titchen (2000) referred to the 'presence' of the facilitator as a physical presence of 'being with', and this is also referred to by Cardiff (2014) in his work developing person-centred leaders. Presence as it is referred to in this study concurs with both these studies, but we also found that the presence of the facilitator was also perceived as something 'virtual' that the practitioners occasionally felt alongside them, and they also asked questions of eg. 'What would Caroline say to me now?' Initially I felt that this was similar to Casement's work around the idea of an 'internalised supervisor' (Casement, 1985), where the student internalises the style of their supervisor and is consequently unable to find their own way of being. Casement implies that this is not ideal, but in this study it actually seemed to have positive

benefits, giving the practitioners both courage to act as well as positive reinforcement when they were in difficult situations. In effect the virtual presence of the facilitator was being used for support. I believe now that instead of being an ‘internal supervisor’ this is a form of ‘buffering’ that the practitioners experienced (Cohen, Wills, 1985). ‘Buffering’ is the effect that social support has on well-being, and it has been shown that this support ‘buffers’ people from the potentially harmful effects of stressful events” (Cohen, Wills, 1985 p310).

“the perception that others can and will provide necessary resources may redefine the potential for harm posed by a situation and/or bolster one’s perceived ability to cope with imposed demands, and hence prevent a particular situation from being appraised as highly stressful”. (Cohen, Wills, 1985 p312)

The idea of ‘buffering’ would appear to explain why some participants described ‘You are on my shoulder’ as the feeling that they have now ‘got support’. It enabled them to do things that previously would have ‘fazed’ them (see p143) and lends a new angle to the inclusion of ‘Presence’ in this part of the Facilitation Triad. The literature suggests that there are four different forms of support, three of which may be relevant to this study. Esteem support comes from a person feeling valued for their own worth and experiences and would be very similar to the ‘unconditional positive regard’ of Rogers (1983), which is one of the underpinning perspectives in this study. Informational support is help in understanding and coping with problematic events and would counter a perceived lack of control; and instrumental support is the provision of material resources to enable direct resolution of a problem. All three forms of support have been shown to derive from one good relationship such as a confidant, but not necessarily from multiple superficial relationships (Cohen, Wills, 1985). Although these studies do not refer to nursing or to specific support in work, they do provide evidence to suggest that in addition to the actual ‘being with’ presence, the ‘virtual’ presence was an essential part of the relationship, at least initially, and this is new knowledge that has come from this study.

It is easy to slip into a dependent relationship when working in a one-to-one situation, and this dependence can work in three ways. The practitioner can become dependent on the facilitator in order to function, the facilitator can become dependent on the practitioner for affirmation, and the facilitator can stifle the practitioner by being

overprotective. The literature around one-to-one supportive relationships concurs with this and contains descriptions of paternalism (Donetto et al., 2017) manipulation (Casement 1985); and transference and counter-transference (Heron, 2001). An integral part of remaining independent is learning how to learn (Rogers, 1983). In this study the practitioners all identified that they learnt skills that would enable them to continue to work in a similar way, even when our time together finished.

## **Maintaining Stability**

The second part of the facilitation triad was using the activities<sup>6</sup> that maintain stability for the practitioner. The idea of facilitation as a technique by which one person makes things easier for others (Kitson, Harvey & McCormack, 1998) has been around for a long time, and it is generally this technical aspect of facilitation that is captured in the activities below. Although there is recognition that expert facilitators should be able to use all forms of facilitation, I believe that their inclusion as an equal part of a facilitation triad in a formal model for work-based professional learning is new, as these tend to be the activities that occur between peers. It is this that makes the Professional Learning Partnership particularly suited to working with nurses in everyday practice as it helps to deal with issues of immediacy. These facilitator activities addressed the practitioners' immediate needs and maintained stability for them in their roles thus making it easier for them to learn.

Taken as a whole the activities in the 'maintain stability' part of the facilitation triad were not about rocking the boat or working with a lot of challenge, but rather they helped the practitioner to work with their current practice and their current knowledge, reducing anxiety, making things do-able, and removing practical blocks. For the practitioner it was a fairly 'safe' way of working where the actions taken were focussed on achieving or working with their existing routines or processes. What is apparent from considering the facilitator activities in this part of the facilitation triad is that if they are used in isolation then the outcome is likely to be a practitioner who is engaging

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<sup>6</sup> I have referred to the activities in this and the following part of the triad as 'activities' and not 'interventions' because I feel that 'activity' better captures the fact that they were engaged in *with* the practitioner in a partnership, as opposed to the word 'intervention' that implies something that is done *to* the practitioner.

solely in single loop learning. The inclusion of these maintaining stability activities makes the role of the work-based learning facilitator as presented here different from the role of a coach, where coaching is not meant to be used to ‘fire-fight’ (McNamara et al., 2014). The problematic context for many nurses in the NHS is the emphasis on targets and safety, and the fear of taking risks or getting ‘into trouble’ for not having done something. The findings from this study therefore agree with the suggestions from Berta et al (2015) that when nurses are working in a context of targets and the culture is one of fear then nurses are most likely to engage with learning activities that make them feel safe. It is not surprising therefore that the activities to maintain stability are an integral part of the professional learning partnership model. Participating in them enabled the practitioners to gain confidence in themselves and their practice and was really about strengthening the bedrock on which their practice was founded.

### **Solving problems**

This is about helping the practitioner to deal with a practical problem. The relevance of this activity was that it removed the issue that was ‘on top’ for the practitioner and left them more able to focus on other learning. As mentioned previously when considering the buffering effect of a supportive relationship (Cohen, Wills, 1985), two forms of support which are more about ‘doing’ could be seen as similar to the activities in this part of the facilitation triad. The instrumental form of support (actually doing something) only acts as a buffer against stress when it is closely matched to the problem. This adds to the understanding of why it was important for the facilitator to occasionally provide practical help. This help was not necessarily a passive activity as it could also be used as a learning opportunity.

### **Making Suggestions**

This the new name for the activity “Giving us Options” and is about the facilitator making suggestions on how the practitioner could approach or do something. This activity was most helpful when the practitioner was ‘stuck’, or devoid of ideas. This activity could be seen as similar to the prescriptive interventions of Heron (1986), which are about recommending a particular line of action, or the strategy of making suggestions based on craft knowledge as suggested by Titchen (2000). Heron identifies that the prescriptive interventions can be used in a variety of ways from directive to

consultative, and at the consultative end of the continuum they are about making suggestions, which fit well into this model. The important feature in this model is that it was down to the practitioner to make the decision whether or not to go with the suggestion. There is a general opinion that a facilitator shouldn't be making suggestions, no matter how tempting it is, but rather facilitating the practitioner to make their own decisions (Mulcahy et al., 2018). In this study, maybe because the facilitator was working with an individual rather than with a group who might be able to pool ideas, the activity was felt to be appropriate.

### **Channelling ideas**

This is about helping the practitioner find their way through the maze of things that needed to be done. It involved the facilitator working with the practitioner to narrow down their field of focus so that ideas went from being so big that they were paralysing, to small enough to make them manageable.

### **Being a sounding board**

This is about listening as the practitioner talked through issues in their practice. These issues were often a cause of anxiety, but the act of talking them through helped the practitioner to organise their thoughts and gave them confidence about their actions. The idea of talking to a work colleague to obtain 'confirmation of actions' has also been recognised elsewhere (Skår 2010 p10), but a lack of time in everyday work tends to limit the amount of time that can be spent on this.

## **Stimulating Growth**

The third part of the facilitation triad was using activities to 'stimulate growth' in the practitioner. These activities focussed on issues that were longer term and were intended to lead to a sustainable change. These activities are comparable to those suggested by Mulcahy et al. (2018)

“The facilitator enables staff to reflect and engage in critical dialogue about their workplace beliefs, values and work practices to create an environment where staff can reflect and challenge rituals and assumptions, leading to action planning to improve workplace cultures and care quality” (Mulcahy et al 2018 p4).

They also fit well with the activities identified in the literature review. The importance of these activities is their function in enabling the practitioners to question the underlying assumptions of both their own practice, as well as the practice in their work areas. Whilst there was inevitably an element of critical reflection in these activities, the focus was not so much on past experiences but rather current practice and what to do next. Finally, just helping people to recognise that things need to change does not guarantee that things will change, so working on concrete plans that are appropriate for the specific nurse, taking into consideration the context they are working in was key in enabling action.

### **Unpicking practice**

This is the new name for the activity ‘Pulling things apart’ and is about exploring the practitioners’ practice with them. It involved listening, questioning and then pointing out things the practitioner had said or helping them to make links to previous issues or learning. Unpicking practice often uncovered the practitioner’s values and beliefs, and the professional issues that underpinned that practice which could then be explored. This activity used Heron’s Catalytic interventions (Heron, 2001).

### **Changing thought processes**

This is about helping the practitioner to question their existing practice and explore whether there was a different way of doing things. This change in perspective resulted in them having a different way of thinking about something, a different way of doing something or a different way of being. Some of these processes are similar to the idea of reframing which is an integral part of Mezirow’s transformative learning theory (Mezirow 2000)

### **Enabling Action**

This is the new name for the activity of ‘Throwing the ball back’, and is about facilitating the practitioners to identify where, when, and how they could take action to bring about the change that they wanted to see either in themselves or in others.

### **Broadening horizons**

This is about adding knowledge to the practitioner’s practice that they may have been unaware of previously. This could include people they did not know were around,



resources they did not know were available, or evidence that they did not know existed. This activity expanded their practice and was similar to informative interventions (Heron, 2001) that are used to pass on information to the practitioner.

## **Balancing the Triad**

A triad is considered to be a set of three things that are seen as a unit, and that is the idea behind the facilitation triad. The intent is to demonstrate that all three parts are important in the whole, not that all parts necessarily have equal attention.

The model is designed to be a framework to illustrate and understand the facilitator's role in professional learning. It is not a formula however, so flexibility in its use is an essential aspect. The facilitator should therefore use the activities in a way that is most appropriate for the practitioner at that moment in time. There is a theoretical possibility that if the activities engaged in are only the ones from the 'maintaining stability' side, then whilst the practitioner would feel supported and their practice would be 'safe', neither they nor their practice is likely to develop as they would just be engaging in single-loop learning (Argyris, Schon, 1996). This raises the question of the need to have regular one-to-one meetings as opposed to only having meetings 'as needed'. If the practitioners only meet when they need 'help' then they may just engage with the maintaining stability side. Hardiman (2017) claims that facilitation does not always need protected time and space away from the workplace, and has developed a method for facilitation called 'Facilitation on the Run' (FoR). My understanding of that method (FoR) is that it is designed for developing facilitators of practice development rather than the individual professional learning that I am suggesting my model encompasses. The need therefore for protected time and regular meetings may not be so important. The evidence also suggests that frequent interruptions and fear of being overheard can inhibit learning. I would argue however that unless practitioners have time and a safe space they are unlikely to be able to engage fully in the four activities identified on the stimulating growth side of Professional Learning Partnership model. However (Dewing, 2010) suggests that practitioners need to move from feeling safe in a protected space to feeling safe in the working environment if they are to have an effect on practice.

## Outcomes

This research has shown that when working one-to-one with a nurse to help facilitate their ‘learning for themselves’ it is not the context of work *per se* that impacts on their ability to learn, but rather how that context and culture makes them feel. It would be hard to disagree with the statement that a facilitator working with individual nurses in a one-to-one relationship is going to make very little direct difference to the overall context of work (Grealish et al., 2015), however this research has shown that even in cultures that are not learning cultures it is possible for individual practitioners to learn and to change their practice if they are supported by a facilitator. Working individually with nurses changes them as people and changes them as professionals. These changes then put them in a better position to take action on their practice. The difficulties with being able to attribute a causal relationship between learning and effects on practice are well known (Clark, Draper & Rogers, 2015), however Johnson et al (2011) felt that they could show a clear association between learning and development activities and work attitudes and performance, and I would concur with that. The outcomes of the facilitation activities in this study begin with the personal and transformational changes to self that have occurred in the practitioners, and how they have then been able to use these personal changes to change the way they act as professionals, and to instigate changes to the way they practice. Barnett (1997), although talking about Universities, argues that rather than focus on critical thinking, the aim should be to develop a critical being. This critical being will be someone who “embraces critical thinking, critical action and critical self-reflection”, and thereby would develop not just their knowledge but also themselves and their practice (Major, 2002 p1). I believe that is what the Professional Learning Partnership has achieved.

### The significance of personal change

“Fundamentally it is the person who learns and it is the changed person who is the outcome of the learning, although that changed person may cause several different social outcomes” (Jarvis, 2009 p24)

At the start of this research a lot of the literature about outcomes of post-registration education concluded that whilst the students reported changes in attitudes and

increased knowledge and skills there was very little evidence of changes to practice (Gijbels et al., 2010). This continues to more recent times, where the overall impact of post-registration (assessed) education is unclear (Cotterill-Walker, 2012, Lahti et al., 2014). The reasons for this are attributable to the difficulty in measuring the impact on practice when there are so many confounding variables (Clark, Draper & Rogers, 2015). Measuring the impact of learning on practice that is not assessed is potentially even more difficult as can be seen from all the attempts to measure the 'impact' of clinical supervision. Although Jones (2003) suggests that practice can be improved through increased understanding, problem-solving and emotional support of nurses, it is a considerable challenge to provide unequivocal evidence of a causal relationship between clinical supervision, better nursing care, and improvements in patient outcomes. A large scale study in Australia set out to show a causal relationship between clinical supervision and improved patient outcomes in mental health, but this relationship remained elusive and provided 'no statistically significant differences in patient satisfaction and quality of care' (White, Winstanley, 2010 p162). However, as that study identified, 'the absence of evidence is not evidence of absence'.

Egan identified back in 1990 that outcomes from a helping relationship tend to start with an increased sense of worth and self-confidence. This leads to an increase in assertiveness that replaces the previous passivity and makes the client more able to act (Egan, 1990). The outcomes for the practitioners in this study followed the same path. The outcomes were all about the self, a way of being, and growth as a professional, and this started with an increase in their self-esteem and self-belief. As professionals they felt that they had more clarity about their role and the impact that they could have in that role. They understood their values and beliefs and were more confident to 'be themselves' in their professional role and take action on things that they had previously felt unable to. These outcomes were spread across the board, with even the practitioners who were the most committed at the start still identifying that the changes that occurred in them as a person had to happen before they could undertake changes to their practice. At the start of this research I was advised by my workplace that they wanted to see some 'concrete outcomes' from the participants and not just that they 'felt better about themselves'. Interestingly, although there were some 'concrete

outcomes' from two of the participants in the study in the form of two practice projects that were shared through Poster Presentations at the Chief Nursing Officer (Wales) Conference in 2012, the practitioners did not identify these projects when asked about their significant achievements from their time in the study. The importance of developing 'self' is picked up in a paper by Ward et al (2017), who found that things such as understanding self, and developing self-awareness and self-efficacy were required to enable staff to work better inter-professionally. The outcomes from this study also demonstrate that when nurses had improved self-esteem and self-belief they were more able to challenge poor practice, and more able to take ideas forward into action. This fits with evidence from a concept analysis of confidence/self-confidence (Perry, 2011), which found that self-efficacy and self-esteem are antecedents of self-confidence. Following their research they added an intra-professional dimension to their inter-professional education curriculum, and suggested further research is needed to understand how students can learn about the 'self'.

The practitioners in this study provided self-reported outcomes, but when working with practitioners who are in control of their learning it makes sense that they are also in control of determining what the effects of that learning have been. Whilst the idea of 'feeling better about themselves' is often scorned as an outcome, Heron (2001) describes feeling as being the foundation out of which everything else emerges. A tree will only bear fruit if it has strong roots, a trunk, and branches (Heron, 2001).

This is not the only intervention that claims a similar spread of outcomes starting from the personal and leading on to practice change. Restorative Supervision (Wallbank, Wonnacott, 2015) is a blend of motivational interviewing and leadership and was designed to support individual Health Visitors who are working with complex families. Its focus is on building relationships and improving communication skills as opposed to learning per se, but the results from restorative supervision studies suggest that reducing the professional's anxiety about managing the complex risks involved in their case-loads means they are more able to think about themselves and their learning needs, and then become creative and energetic enough to think about developing their service.

## Changes to Practice

In order to maximise the impact of learning on practice, the importance of a positive, supportive, organisational culture has been said to be vitally important (Clark et al 2015). That would correspond to the findings from this study in that the two nurses who had posters of practice change were both from environments with supportive line-managers. For the nurses who did not have a particularly supportive working environment the changes to their practice were things that they could do by themselves with no input from anyone else. This may explain the lack of evidence of practice change if it has all been undertaken in small personal ways. Whilst it is recognised that these changes are not going to have an enormous impact on the overall context and culture of the clinical area, for people who came into contact with these practitioners then it is likely to make a difference. In addition just by being active, questioning themselves and sharing their learning the practitioners were able to effect change on their colleagues, thus demonstrating the overall impact that they could have in developing the workplace into a learning environment (Skår 2010).

In the model for a Professional Learning Partnership the focus is on helping nurses to learn so that they can change themselves and their practice, which is a future oriented idea. This helps to align this model with the ideas in Scharmer's Theory U (2009), and in particular the idea of enabling people to reach their highest future potential, and to move from where they are now (the self) to what that can become (the Self).

The essence of Theory U is fairly simple. On the downward arm of the U it involves becoming aware that simply following the 'patterns of the past' (Scharmer, 2018 p24) means that nothing will change (Downloading); looking at things with fresh eyes (Seeing); and redirecting attention to the source of the problem rather than the effect (Sensing). Having done that is the moment where we let go of the previous way of working and connect to what things could be like (Presencing). This occurs at the bottom of the U. Then as we move up the other side of the U we match our vision with action (Crystallizing); learn by trying out the change (Prototyping); and finally embody the new way of working (Performing). As suggested by Scharmer (2018) the whole is in three movements of observe (going down the U), retreat (the bottom of the U), act (coming up the other side of the U). In the figure above I have mapped the

activities from the facilitation triad onto the Theory U diagram. The activities from the Professional Learning Partnership (PLP) that maintain stability are located in level 1 and 2, however they could be used at any point in the U to provide stability to the practitioner on the journey through the U. The trusting partnership is central within the U indicating its importance to working with the practitioner. Unpicking practice is associated with the downside of the U by looking at current practice, changing thought processes is associated with the bottom of the U as the practitioner lets go of their way of being that was keeping them in their previous practice, enabling action is matching vision with action and trying out new actions.

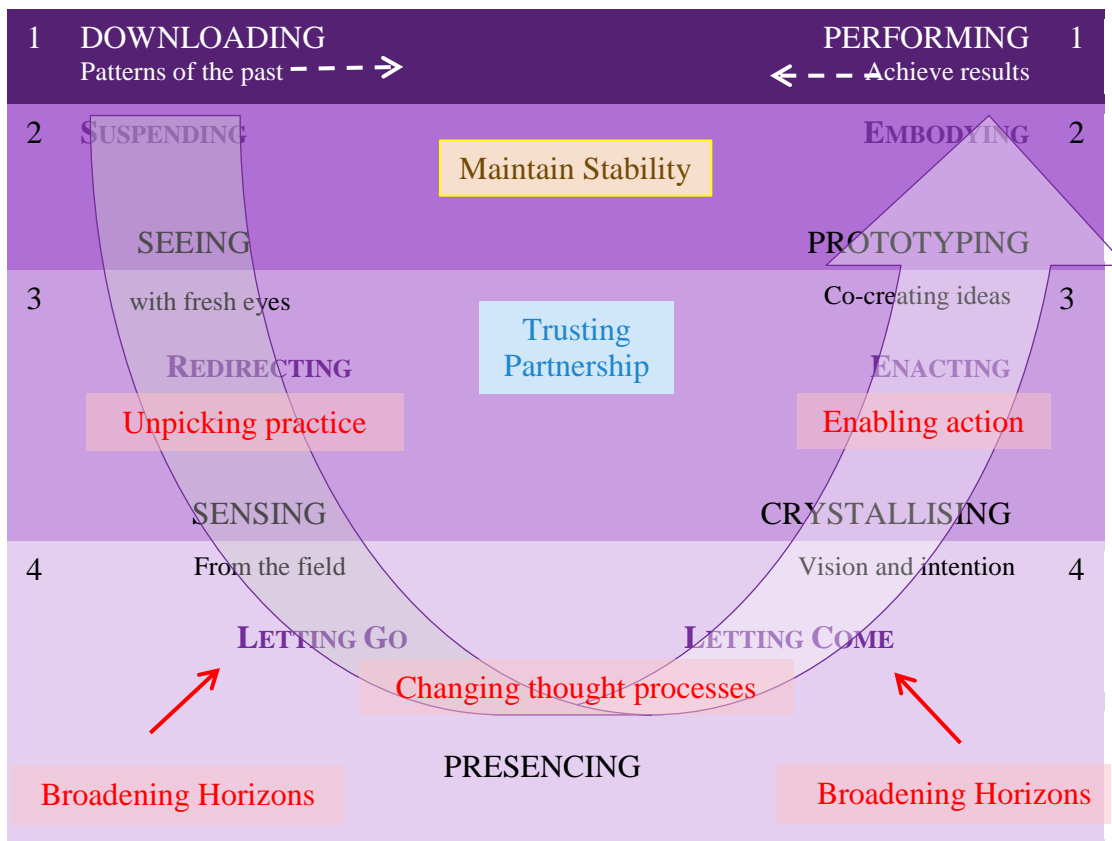


Figure 26: Theory U (Scharmer 2009 p38) with superimposed activities from the professional learning partnership model

Scharmer (2009) identifies that the majority of organisations work and remain in levels 1 and 2, so they identify that things need to change but never actually move to do anything about it. Or they do try to do something about it by ‘implementing’ solutions and trying to bypass the bottom of the U and the change in the person. This could also be used to explain why learning does not always lead to a change in practice, because the learning helps people to identify that things need to change, but without help they

are unable to take it any further. The evidence from this study demonstrates the difference that a facilitator can make to this process, by accompanying the practitioner on the journey into the deeper levels of the U. The practitioner is then supported through the trusting partnership while they pass through the ‘eye of the needle’ (Scharmer, 2009 p185) and into a different way of being.

This helps to understand the one area that was perceived as negative from the study. This was the feeling that, once the practitioners had ‘changed’, they were somehow living in a parallel universe. Their colleagues and the system were still back in the space that they had now left behind. This has been raised previously by Kitson (1997) who suggests that there is a danger that these nurses may be seen as troublemakers unless there is also a change in organisational culture to keep up with them.

The table below takes the seven spaces identified by Scharmer (2009), and then links that to what we were actually doing in the study, and how that relates to the PLP model. Both of these identify how through working in a professional learning partnership a facilitator could assist practitioners to change themselves and thereby their practice which has been demonstrated in this study. The ability to link the PLP model so closely with Theory U (Scharmer 2009) demonstrates the practical potential for a Professional Learning Partnership to enable practitioners to change their practice as they learn.

*Table 5- Comparing the Professional Learning Partnership with Theory U and relating both to the practitioners' experiences in this study*

	<b>Theory U</b>	<b>Reality for Practitioner in this study</b>	<b>Professional Learning Partnership</b>
<b>Level 1</b>	<b>Downloading –</b> Re-enacting patterns of the past – viewing the world through one’s habits of thought	Where the practitioner was at the start. Not seeing what they were doing, or seeing it but not saying anything about it because of the culture	
<b>Level 2</b>	<b>Seeing -</b> Suspending judgement and seeing reality with fresh eyes	Painting their visions. Recognising where they are currently and recognising that perhaps things could be different.	<b>Broadening horizons</b> - adding knowledge to the practitioner’s practice that they may have been unaware of previously + <b>Maintaining Stability</b>

<b>Level 3</b>	<b>Sensing -</b> Connecting to the field and attending to the situation from the whole	Working together to look at current practice. Recognising that mindless working just reinforces the same old system. Exploring how our values and beliefs impact on ourselves and our practice.	<b>Unpicking practice</b> - pointing out things the practitioner had said or helping them to make links to previous issues or learning. It uncovered the practitioner's values and beliefs that underpinned that practice which could then be explored.
<b>Level 4</b>	<b>Presencing -</b> Connecting to the deepest source, from which the field of the future begins to arise	"In order to move through the eye of the needle we must look at old issues in new ways and bring our real selves into the situation" (Scharmer 2009 p179)	<b>Changing thought processes</b> - question existing practice and exploring whether there is a different way of doing things.  "problems can never be solved with the same mind that created them" (Einstein)
<b>Level 3</b>	<b>Crystallizing -</b> Vision and intention – envisioning the new from the future that wants to emerge	Enabling action	<b>Enabling Action</b> - identifying where, when, and how practitioners can take action to bring about the change that they want to see either in themselves or in others.
<b>Level 2</b>	<b>Prototyping</b> living microcosms in order to explore the future by doing – enacting the new	Supporting practitioners as they start to live out the changes in themselves	<b>Broadening horizons</b> - adding knowledge to the practitioner's practice that they may have been unaware of previously. + <b>Maintaining Stability</b>
<b>Level 1</b>	<b>Performing and embodying</b> the new in practices and infrastructures – embedding the new in the context of the larger co-evolving ecosystems	Embodying into everyday practices	



In addition to the compatibility with Theory U (Scharmer 2009) I believe that the Professional Learning Partnership also has a close relationship with the Person-centred Practice Framework (McCance and McCormack 2016), and in particular the pre-requisites which focus on the attributes of staff. These attributes include being committed to the job, clarity of values and beliefs, professionally competent, developed interpersonal skills, and knowing self. Throughout the work that the facilitator and the practitioners did together in the Professional Learning Partnership there was a focus on these attributes and how they underpinned every other aspect of their practice. Whilst recognising that the care environment was not conducive to person-centred ways of working, I would suggest some of the practitioners did achieve person-centred moments in their work with patients (McCormack, McCance, 2010), which could be seen as the first step towards person-centred care.

## **Summary**

In this chapter I have discussed the findings from the research. These were structured around the four main themes, and the overall synthesis of the themes into a model for a Professional Learning Partnership. The model for the Professional Learning Partnership contains the facilitation triad, which encapsulates the role of the facilitator in work-based learning. I have described the model and discussed it in the light of existing literature to show how it supports other work around facilitation and learning.

In a field as crowded as facilitation it is a challenge to develop large pieces of original work, however every small element adds to the overall development of the knowledge base. I believe that the model that has been developed through this study has added new knowledge to the field. This is through the visual representation of the model, which captures the key elements and can be recommended for its simplicity. I have also explained how the explicit addition of the activities in the maintain stability part of the facilitation triad make this model suitable for use in areas and with practitioners where there is not a particularly supportive learning environment, or an environment that would support person-centred practice. Whilst there has always been recognition of the need for a facilitator to be flexible and use the whole of the facilitation continuum (Harvey et al 2002), the acknowledgement that these are an important part

of working with nurses in practice is new.

In addition to the development of the model this study has also added to the debate about the appropriateness of written reflections for practitioners who are not undertaking academic work.

The next chapter will consider the way the study was carried out in an attempt to demonstrate its trustworthiness.

# **Chapter 7 – Looking Back**

## **Introduction**

The previous chapter discussed the findings from the study and positioned them in the context of existing literature. It articulated the new knowledge that the study has contributed to the field of facilitating work-based learning. This includes a new model for a Professional Learning Partnership (PLP), and a new methodology for undertaking person-centred, action-oriented research that uses facilitation to support learning. This chapter will look back at the study itself. It will consider the way the study was carried out and the people that were involved and how both of these things influenced the findings. The aim of this reflexive review is to help surface some of the hidden issues that surround the study, and through this demonstrate its trustworthiness, credibility, and dependability (Guba, Lincoln, 2005). In order to undertake this reflexive review I will look at the study from 3 angles, a) An introspective viewpoint which will consider my position as both the researcher and the facilitator b) A relational viewpoint which will consider the relationship between me and the practitioners and the impact of this relationship on the study c) An epistemic viewpoint which will consider how the methodology supported the generation of new knowledge from the study.

## **The Context**

The organisation I was working in was in a state of considerable flux when I started the research in 2010. Six organisations covering both community and the acute sector had been merged into one and there was an almost continuous re-organisation process going on. Most of the features of a learning organisation (Manley, Titchen & Hardy, 2009) were missing. This inevitably had an impact on the nurses that worked in the organisation and also impacted on how I was able to operationalise the study. When I was in the preliminary stages of planning the research I went to talk to some staff nurses. I wanted to know if what I was thinking of doing might be something that they would be prepared to participate in. The response that I got from a staff nurse (below)

summed up the climate in the organisation at that point in time. It upset me a lot, not least because the staff nurse came from the hospital where I was currently working.

*“What we really need is someone to be interested in our work. To notice what we are doing. To say thank you with meaning. Sometimes even when someone tells you off for something that is better than nothing, because it means they have noticed. What is worse is the feeling that no-one notices and no-one cares”. [Staff Nurse]*

*Reflective Diary: June 2010*

In 2011 my position as employee, learner, researcher and facilitator were all tied up in the same organisation. Prior to entering the field I needed the agreement of the nursing service that they would allow the nurses’ time to participate. In the event it took six months to get this agreement. The Director of Nursing had been very supportive, encouraging and excited about the research when it was first discussed (mid 2009) and even had it put into my job description. However, by the time I was ready to enter the field at the end of 2011 priorities had changed. The Director of Nursing had changed since REACH was introduced. The pilot study had finished and consequently the steering group had been disbanded. To ensure parity across the new organisation I was tasked with continuing the roll out of the REACH programme despite the problems with facilitation that had been identified in the evaluation of the pilot study. In 2013 the organisation made REACH ‘optional’ and soon afterwards it had all but disappeared.

## **My position as both facilitator and researcher**

The current complexity in the context and my position as an insider in the organisation as well as completely embedded in the research had both positive and negative consequences me and for the study. As the facilitator I was working with the practitioners to help them to learn through their work, and as the researcher I was trying to tease out an understanding of the facilitator role. My positioning within the research was a deliberate choice to ensure coherence with the philosophical position of humanistic existentialism that emphasised the importance of participating in the act of knowing rather than simply observing it from an external position (Macquarrie, 1972).

As the researcher I had to be embedded in the action I wanted to understand, and this is one of the areas where the research methodology was very successful. Working in both roles however inevitably raised some challenges for me. The first issue I came up against was how I portrayed myself in the research. The second was the potential role conflict when obtaining data as a trusted facilitator and then presenting that data as a researcher.

## **Painting a picture**

Describing the two roles as above implies that I am able to split myself into two parts. This of course is not possible. I am one person, and everything that I do is done with my whole being, so inevitably the two roles were closely merged. I believe that was the right approach and what was intended from the philosophical positioning. Working in both roles meant that I was able to choose how I portrayed myself as a facilitator. I was deliberately embedded in this research and not an uninterested observer. I was also in the position to decide what examples were used to illustrate the one-to-one conversations with the practitioners. Pictures are painted by what we leave out as much as by what we include, and I had to make the decision how I would portray myself as a facilitator. I could go one way and select examples that portrayed my facilitation at an expert level, or I could go the other way and select examples that portrayed it at a beginning level. The reality was that I considered myself as a ‘developing’ facilitator, knowing a fair bit of theory but learning all the time through putting it into practice. I know I made mistakes along the way, sometimes missing barn-door cues, sometimes being quite clumsy with an intervention, not always asking the right questions, and not always challenging the practitioners on their choice of language. I also know that some of what I did was very effective, that I did pick up on subtle nuances, and that I asked some very astute questions that made a significant difference to the practitioner in the longer term. I know that as the facilitator there were times in the middle of conversations that I made deliberate choices to act or to not act. My dilemma was whether I should try to explain these or just leave them to speak for themselves. If I did explain them then I had to decide if I would do that as the facilitator or as the researcher. In the end I went back to my methodology for help with making the decision. My research was participative, so rather than making the decisions on my

own I decided that I would only use the examples that were identified by the practitioners either directly or indirectly eg. If Gwen talked about a facilitation activity in the creative reflective analysis workshop that she felt had really helped her, then I would look back through the meetings that I had with Gwen to find the example that she was referring to. If two practitioners identified a similar activity, then I would find both the examples and as the facilitator I would choose which one I felt was the clearest example of that activity. Working in this way meant that the 'choice' of which examples to use became a collaboration between the practitioner and me as both researcher and facilitator. I also made the decision that the quality of the facilitation would be as it was. Nobody is perfect, and it was not my intention to portray facilitation perfectly. By including extended abstracts from the data I would enable others to make their own decisions as to the level of skill I was demonstrating. Where appropriate I would also add information about my thoughts at the time to shed some further light on the processes I used. My intention with this was to make sense of what had happened so that others could understand. I also wanted to demonstrate realness and authenticity in my facilitation practice and research practice and I feel that the way I presented myself achieved this.

### **Getting the balance right**

I don't believe that my position as both facilitator and researcher impacted in a negative way on the practitioners during the facilitation aspect of the study. They only ever saw me as one and the same person, and the fact that I was doing both roles did not seem to concern them. The process reviews at the end of the one-to-one meetings are a normal part of facilitation practice and the practitioners would have experienced these even without the research. In addition, as a facilitator I would have made notes for myself after the session to ensure continuity between one session and the next. Without the research I would still have made some reflective observations on the session to assist with my own learning and development.

As there were so few participants in the study, the practitioners' line-manager, friends and a lot of their work colleagues knew that they were participating. Working with a small group increases the risk of breaching confidentiality (Damianakis, Woodford,

2012) My inability to guarantee absolute confidentiality for the practitioners because of this had been mentioned in the ethical approval, in the participant information sheet, and in the preliminary discussions that we had prior to them joining the study. The practitioners all said they understood this and were in agreement with it. Once the study started however seeing their words transcribed in the process reviews caused a few of the practitioners some concern (see below). The fear that the participants had shown about their meeting records being seen by someone else became a bigger problem for me when I started to transcribe excerpts from the one-to-one sessions to illustrate the themes. As the facilitator I had worked with the practitioners to develop a trusting relationship so that they were able to be open and honest during our one-to-one conversations to enhance their learning experience. I knew that the relationship between the facilitator and the learner was important in enabling effective learning (Rogers 1983). I have commented in the findings chapter that the level of openness and honesty from the practitioners was what had enabled me as the facilitator to help them to change their practice. It was as the researcher however that I had obtained word-for-word recordings of this work. Whilst acknowledging that the practitioners were autonomous individuals and responsible for deciding what they revealed during the data analysis workshop, I had to also be mindful of the fact that during the one-to-one sessions the practitioners trusted me as their facilitator. It has been recognised that when the researcher and participants are more deeply involved with each other the personal sharing may be deeper and more extensive (Rowan, 2006). I therefore considered long and hard whether this had caused them to expose more of themselves than they might have done if the one-to-one meetings were being recorded by an ‘outsider’ researcher.

I recognised that my embedded position as both facilitator and research had put me in a position of considerable power (McDermid et al., 2014). As the researcher I had access to this data, and I wanted to use it to illustrate the work we were doing, but I was very aware that my personal relationship ethic of care extends beyond the research. I have to ensure that the results of the research and the way it is written up do not have unintended negative consequences for the practitioners involved. I was also undertaking person-centred research from an humanistic existentialist position,

and I didn't believe that I should use the practitioners simply as a means for me to achieve an end.

I struggled with how to craft the findings so that I got the balance of detail right, making sure that identifiable features were removed but that there was enough detail to make the findings credible (Bickford, Nisker, 2015) I was open and honest with the practitioners about my anxieties. I explained how I was going to present the data (removing all identifying features from the extracts and using pseudonyms), and I reassured them that I would let them see the excerpts before they were submitted in the thesis. The anxiety that they might be unhappy with what I had done or might feel that I had somehow betrayed their trust or let them down caused me to procrastinate for a considerable period of time. Damianakis and Woodford (2012) believe that preventing harm to the participants takes precedence over the generation of new knowledge from the study, something with which I concur. In addition to the removal of identifying features I have therefore also placed the extended transcripts in an appendix so that if necessary the access to it can be restricted. When I did share the draft findings chapter and the appendix with the practitioners they were however all happy that they were not individually identifiable.

I believe that the decisions that I made during the study to mitigate some of the potential issues around accurate portrayal of both the facilitator and the practitioners have contributed to the believability of the findings.

## **The impact of the relationships on the study**

A researcher who is undertaking research from the position of a personal relationship with the participants can leave themselves open to criticism for not having enough distance to be able to 'see' things clearly. I am however comfortable with my way of working as I believe it is congruent with my underpinning philosophical stance.

In this study my practical engagement was based on the principles of person-centredness, working with the practitioners in a personal relationship that is predicated on mutuality, equality, freedom and trust. It is in this sort of environment that I believe the effective co-creation of knowledge can occur. Although there are a variety of



philosophical approaches to person-centredness, I am using an approach that views personhood as authenticity. My understanding is that a personal relationship means that I am one element in the complex 'you and I' with another person. In order to know a person I must commit myself to them and must be prepared to reveal something of myself. But that alone is not enough, because if I am to get to know another person then that person must also be prepared to make an act of mutual commitment to me, and they must be willing to reveal something of themselves to me (Macmurray, 1961). They can however intentionally isolate themselves from me (or I from them), so that our relationship becomes impersonal. The knowledge that would then develop is knowledge about the other person – the 'you' – but knowledge of them only by observation and inference, as an object in the world, rather than knowledge of them in personal relation to me – I know about them, but I do not know them (Macmurray, 1961).

“No amount of observing another person, no amount of thinking about another person, will ever bring about what is achieved in actual encounter which requires acts of self-revelation and self-commitment one to another” (Duncan, 1990 p78).

I think that this demonstrates that the close personal relationship that we developed as part of the learning side of the methodology was the best way to develop a meaningful understanding about facilitation.

Maintaining a personal relationship between us was important too when it came to the enquiry side and data analysis. An impersonal relationship has the potential to silence the participants. In order to prevent this the initial data analysis was done in conjunction with the practitioners, and then I undertook the further analysis based on their initial work. To illustrate the findings significant events from individual practitioners were taken and used as wholes rather than as disembodied sound-bites. It was for this reason that the one-to-one sessions were not transcribed. This way of working ensured, as far as was possible, that the practitioners' experiences of facilitation were being interpreted in light of their working context and who they are as people. It also safeguards against losing the subtle differences and variation between practitioners (Leonard, 2010).

It is recognised that not all relationships are the same or need to be the same. Functional relations are those that help us to get things done in order to achieve our purpose, whereas personal relations exist in order to help us be and become ourselves (Macmurray, 2004 (1941)). It could be suggested therefore, that whilst a personal relationship was appropriate for the facilitation, I could have worked in a 'functional' relationship with the participants when they were participating in the data analysis done. To be authentic to myself and to the research however, it was important that we valued each other simply because we are people rather than because of the role we were playing, so no attempt was made to change the relationship between us throughout the study.

The positioning of the relationship as 'personal' had the potential to impact on the generation of knowledge from the research. There is always a concern as to whether the practitioners were only telling me what they thought I wanted to hear. As participants in the research the practitioners were keen to be 'helpful'. Occasionally one of them would ask me if I was getting 'good data' from them. The aim of the research meant that as I wasn't trying to 'prove' that something worked but rather to understand it, I was able to obtain 'good data' simply through the fact that they were prepared to participate and work with me. Understanding requires knowing what works as well as what doesn't, so by letting me know if I was doing something that wasn't working for them they were also providing me with 'good data'. In some cases I believe that the practitioners just omitted to mention things that didn't work for them (c.f. Hill, Crowe & Gonsalvez, 2018) which was why the data that was themed and interpreted was only the data that had been identified and discussed in the data analysis workshop as being 'helpful'. Looking at the 'issues' that the practitioners raised from their creative work (Appendix 5C) that were then discussed in the workshops there was a great deal of consistency between all 6 workshops, which lends confidence to the belief that we did capture all the significant issues. In addition it is possible to see the congruence between this table of issues and the final model.

## **Individuals in a group**

The relationship between the practitioners and me was not the only relationship that was apparent in this study. Four times over the course of their time in the research the practitioners and I met together as a group. Whilst I was spending time with each practitioner and developing a trusting partnership this was not the case for the practitioners with each other. When I was recruiting participants, I took into account whether they had had a previous relationship with me. What I had not considered however, was whether or not the participants knew each other, and if they did, whether that would inhibit their participation in the workshops. The data analysis work as a group was an important part of the study, and I have explained elsewhere the concerns that the participants had with their one-to-one meeting data being shared with the other participants, and the steps that we took to deal with that. Once that issue had been addressed there were no further problems with the practitioners talking freely about their experiences. The potential difficulties that can arise when working with research participants who are connected to each other in some way is explained by Ummel and Achille (2016) as internal confidentiality. They describe this as

“The possibility that research participants involved in a common study will be able to identify each other on the basis of published information”. (Ummel, Achille, 2016 p807)

This is a very real issue when working with small groups who are interviewed separately. In this study although the group work was actually done together, it was the one-to-one meetings that were comparable with individual interviews in that no-one else was present. The content of one participant’s one-to-one session itself was unlikely to harm any other participant, however being able to recognise each other had the potential to lead to a wider loss of confidentiality. To try to mitigate this risk we spent the first group day (the introduction day) helping the practitioners develop a relationship with each other, and also worked through terms of engagement that included respecting each other’s confidentiality if they wanted to discuss issues outside the research with colleagues.

# **The Generation of Knowledge**

## **Study coherence**

The decision to develop a new methodology for the study was not taken lightly. The work required to deconstruct Critical Companionship (Titchen 2000) so that I understood how it had been developed, along with learning about critical enquiry so that I could successfully merge them together ensuring that they were philosophically aligned with humanistic existentialism took a long time. Working out how to articulate what I had done took longer, with huge challenges in deciding what to put in the chapter and what to leave out. In the end the written aspect of developing the methodology was like the 10% of an iceberg that can be seen above the surface of the sea, with the background work making up the other 90%.

Existentialists view people as embodied beings, where the reasoning and cognitive powers that they show are simply the visible part of a much deeper and wider engagement with the world (Han-Pile, 2009), and it is through this practical engagement with the world that people develop knowledge (Cooper, 2012). A proper investigation therefore requires methodologies that include practical engagement, and theoretically the methodology worked well to frame the study. On first sight it appears complex but setting out the methodology visually made it much easier to understand how the two parts of learning and enquiry worked together as one whole, and how all of the methods – facilitation, data collection and data analysis were made coherent with it and with each other. The two parts to the methodology made it perfect for a researcher who was embedded in the action, focussing on the learning part when considering the facilitation role, and on the enquiry part when in the researcher role. Without a methodology that held both aspects of the role I believe one aspect would have been privileged over the other, and it is quite likely that the practitioners would have been objectified in one part or the other.

Setting the methodology out as I did effectively reduced the complexity of critical companionship as I used just the process concepts from the three main domains plus the overarching domain in the methodological map. In addition, by combining the process concepts with the constructs of a critical enquiry I was able to develop new

names for the combined domains that also made Critical Companionship easier to understand and explain. In reducing the complexity of critical companionship it is possible that I have lost some of the depth of understanding that it gives to the process of facilitation, but I did this with approval from Angie Titchen, and I believe that the elements that I retained are enough to still legitimately refer to it as Critical Companionship.

### **The flexibility of the methodology**

The methodology demonstrated that it could frame and hold the study but still enable flexibility, which was an essential requirement to fit the philosophical position. At the start of the study a few of the practitioners were concerned by the reality of sharing data about themselves. They did not want me to share the records of their individual meetings with the other practitioners for the data analysis workshops. This was despite agreeing to this in the consent form, the participant information sheet, and our initial discussions. Their concerns meant that the method of participatory data analysis had to be changed from a Creative Hermeneutic Analysis (Boomer, McCormack, 2010, Van Lieshout, Cardiff, 2011) to a Creative Reflective Analysis. The key difference in these two methods is that in the hermeneutic analysis the participants undertake their creative work based on their intuitive grasp of all the material that they looked at, and then as a group start to theme the data based on their shared understandings. In the reflective analysis the participants undertook their creative work based on their own personal reflections that were then discussed in the group. I then carried out the theming of the data on my own. The methodology provided the guide that helped to make sure that the method of participatory data analysis that replaced the original plan was still guided by the creative, dialectic, reflexive, and critical principles of the 'Being Facilitative' domain. This adaptability of the methodology means that it would be possible for other methods to be used, providing they follow the concepts that sit within the domains. This incident also demonstrated the use of process consent.

I believe that the methodology is robust enough to be transferrable to other contexts that are undertaking research with facilitation as an integral part.

## **Active participation**

The humanistic existentialist approach to research requires having faith in people and believing they are capable of actively participating, and as a researcher it means embedding oneself in the research process and being open, authentic and non-defensive (Rowan, 2006). Heron (1981a) believes that direct interaction between people enables each person involved to understand and ‘feel’ the other to a much greater extent than when simply observing an interaction between others. This awareness of the other person as a presence deepens “when we are in a very aware, committed, concerned, exploratory, inquiring relationship” (Heron, 1981a). This intentional personal relationship between the researcher and the practitioners resulted in a participative approach to the enquiry, and meant that although the practitioners did not exercise control over the research, they were involved in the action, in some of the decision-making as the study progressed, and they shared in the learning and co-construction of knowledge. McIntyre (2008) argues that what is important in a participatory project is “the quality of the participation that people engage in, not the proportionality of that participation” (McIntyre, 2008 p15). She advocates researchers and participants working together to define the most practical and doable ways for them to participate and believes that this leads to participation being viewed as a choice not an imposition.

The expectation in the study was that the practitioners would participate in the one-to-one facilitation, participate in the collection of data by contributing their own records, and participate in the analysis of the data including starting to theme the issues through the hermeneutic analysis. In the event the practitioners did not keep their own records because they didn’t have time in work and were not prepared to do it at home, something which has been noted in other studies (Ramage 2014). This reduced the variety and source of data for the study as a whole, but also highlighted other important aspects of the reality of work-based learning. As mentioned previously the practitioners were also unwilling to have their one-to-one data shared so were unable to progress from the first stage of data analysis into theming the data, which I then undertook on my own. In hindsight and knowing the prevailing context within the

Health Board these full plans for practitioner participation were probably too ambitious.

## **Caught up in the doing**

An aspect of the methodology that needs further consideration of how to operationalize was around the practical aspects of being both the researcher and the facilitator. As I was working in both the roles, I was effectively working on my own. When starting in the field I found myself completely caught up in the ‘doing’ aspects of both roles as an excerpt from my reflective diary shows.

*It is so easy to get caught up in the ‘doing’ at the expense of learning. In this respect I have mirrored the participants who have been so caught up in their everyday practice that they did not have time to stop, think, and learn. I too have become so involved in ‘doing’ the facilitation, ‘doing’ the field notes, ‘doing’ the data analysis that I have not really focussed on the ‘being’ and ‘becoming’ aspects of the study as they relate to me. So whilst I have inevitably learned from simply doing I now recognise that I need to intentionally focus on developing myself and my skills as a facilitator so I can turn this learning back into the study.*  
*Field Notes: March 2012*

This aspect of getting caught up in the doing at the expense of being and becoming, (or in a desperate attempt to improve the being and becoming) was identified by van Lieshout (2013) during a participatory action research project in her PhD work. She recommended connecting on a personal level with a support system and engaging in critical and creative dialogue to enable ‘grounding’. However, like the practitioners in this study I have at times felt as if I was working in a ‘parallel universe’ to those around me. Everything I believed in and was trying to do was not something that was really understood in my workplace. As I developed a greater understanding of ‘Self’ I felt that the team had a more ‘technical’ approach than mine, that research was viewed more from a positivist perspective, and being person-centred was interpreted as ‘patient-centred’. I don’t believe that this is an unusual feeling in qualitative researchers as they start to explore their field (Herman, 2010)

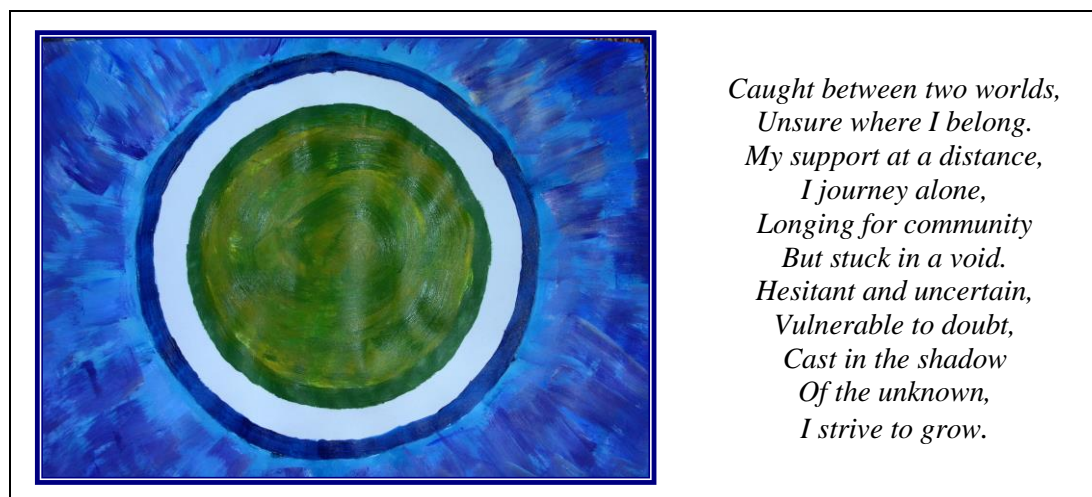


Figure 27: Creative work and poem that captured my feelings of being in a parallel universe

The difficulty with being on my own became most apparent practically when I was facilitating the creative reflective analysis (CRA) workshop. Whilst there were benefits in that the practitioners knew me and were therefore comfortable with my presence, I think an additional person would have added a more critical edge to the discussions in the workshop. In the facilitation I had recognised the benefits of the facilitator not knowing the participants' clinical areas so they could ask the stupid question, and challenge thought processes or ways of working during the one-to-one sessions. However, when it came to facilitating the CRA workshop I was so embedded in the facilitation work (the 'Being Present' domain) that I found it difficult to take everything in, and to see alternative viewpoints. I knew all the events that the practitioners were talking about as I had been there. Although this may not have changed the overall understandings that developed from the research, it may have increased the participants' individual knowledge and understanding, and it may have increased my knowledge and understanding. As an example, whilst discussing the contextual issues that impacted on their learning I did not pick up and discuss with the group the impact that they as individuals were having on their own learning eg. the learned helplessness. These things had been mentioned by the participants in various ways and were obvious to me once I began to theme, sub-theme and interpret the findings. If I had picked up on it during the CRA we could have specifically discussed ways of addressing it, which would have added to the criticality of the study and may have enabled an even greater impact on their practice.



## **Limitations of the Study**

I recruited 10 people to take part in the study of whom 2 dropped out. The two practitioners who dropped out did so because one went on long term sick with a physical problem and the other had a family emergency that took their focus elsewhere. The study was therefore only carried out with 8 practitioners, although this is a reasonable number for an in depth qualitative, action-oriented study. In a similar way the study was based around one facilitator, and a different facilitator or a facilitator with more, or less, expertise may have found that other facilitation activities were more successful. For this reason the focus was on the activities undertaken by the facilitator rather than the specific processes that they used to achieve those activities.

I had made no attempt to set criteria for recruitment beyond the fact that they should want to participate and not be currently undertaking an academic course. The majority of the nurses I recruited were from medical specialities. This was due to the association with the REACH programme. At the end of the awareness raising sessions about REACH I let people know that I was recruiting for the research, and at the time I was taking REACH out to the medical directorate across the Health Board. REACH was already in use in the Critical Care Directorate and the Surgical Directorate, and all the wards and clinical areas had information leaflets about the research. Despite this I did not have any participants from surgical wards, no paediatric nurses, no mental health nurses, and no nurses from the critical care or emergency units. It has been identified that the practitioners made a decision whether to participate based on whether they thought they could get on with me, so the face-to-face information giving was probably the explanation for the uneven distribution of participants. Despite this the participants had a good mix of expertise between them having been registered nurses for between 3 and 30 years. I was particularly pleased that I initially had five staff nurses considering the difficulty they normally have to get time out from practice. The participants were spread across the Health Board coming from all three Counties and from both secondary care and the community. I do not think therefore that the uneven distribution of nursing speciality was detrimental to the study. All of the people who volunteered to participate however were women. The study could be criticised

therefore because the participants were all of the same gender, and it may be that men would benefit from being facilitated to learn in a different way.

The study took also place with nurses who were working in clinical practice and some of the practitioners needed and wanted to learn clinical skills and develop their clinical knowledge as they were new into posts. The facilitation was not about teaching clinical skills, so my role was limited to helping them decide how they were going to achieve the learning that they wanted to, and then how they could apply that learning to their practice. The practitioners therefore needed an alternative source of clinical expertise if they wanted practical clinical help. In reality this is how most nurses learn skills in practice. The model is for facilitation and not teaching, and therefore the approach taken in the study was felt to be appropriate for the staff involved. It could be an extension of this study however to determine how well it would fare being used within practice.

## **Summary**

In this chapter I have reviewed the study reflexively to come to some conclusions about its trustworthiness. I reviewed my position in the study as both researcher and facilitator and considered how that impacted on the decisions I made about the one-to-one data to use to portray myself as the facilitator. I also looked at how I reconciled the issue of obtaining data as a trusted facilitator, and then presenting that data as a researcher. I also considered the impact on me personally of being both the researcher and the facilitator. The key issue in this case was one of loneliness and working alone to operationalize the study. My intention with reviewing my own position in the research was to demonstrate realness and authenticity in my facilitation practice and research practice and I feel that I have achieved this.

Secondly, I considered the relationship between the practitioners and me and how that impacted on the study. In particular I considered how that might have impacted on the data collection. I believe that the relationships in the study were appropriate for the purpose, and once developed it was inappropriate to try to withdraw into a more functional relationship. In addition, I propose that the congruence between the issues

that emerged from all six data analysis workshops, and the alignment between this table of issues and the final model lends weight to the truthfulness of the data.

Thirdly I considered the new methodology and how that enabled the generation of knowledge. I considered the study coherence, the flexibility of the methodology, and the participation of the practitioners. From these considerations I have shown that the methodology has simplified Critical Companionship, but not enough to lose its meaning. The methodology demonstrates the coherence in the study between the philosophy, methodology and the methods. The flexibility of the methodology is demonstrated by the change that was made to the methods to accommodate the practitioners' concerns. There are two areas where the methodology did not work so well and these were being a lone facilitator/researcher, which I believe reduced the criticality of the potential learning for the practitioners and for myself, and the participation of the practitioners in the research, which was less than was intended. I believe overall that the methodology functioned well to guide and shape the research and is robust enough to be transferrable to other contexts that are undertaking research and facilitation together.

Finally, the participants in the study were all women, which may limit the applicability of the findings to men.

Overall I believe that this chapter has helped to demonstrate the trustworthiness of the study. The understanding that has been developed from this study is not generalizable, but it is transferable and could be used by other facilitators and learners to develop effective professional learning partnerships. In the following chapter I will consider the implications for practice of the new knowledge that has been developed through this study, and how this new knowledge could be developed further. I will also consider how the research methodology could be used in other studies.

# **Chapter 8 – Looking forward**

## **Introduction**

This study started out to consider the role of the facilitator in enabling nurses to learn through their work. The idea of work-based learning is that it enables a nurse to change both themselves and their practice, something that doesn't happen very often after classroom-based learning. In the REACH programme it was known that facilitators made the difference to nurses attempting to learn and make changes to their practice, but exactly what the facilitator did to achieve this was unknown. This study has developed an understanding of that role and has turned that understanding into a model for a professional learning partnership. The previous chapter contains a reflexive review of the study in order to demonstrate its trustworthiness. The knowledge developed from the study is recognisable to other facilitators and although not generalisable, it is believed to be transferrable to other settings. This chapter will therefore consider how that knowledge could be transferred into everyday practice so that it can be used to develop robust professional learning partnerships.

## **Feasibility for implementation into practice**

The Professional Learning Partnership has been developed with Registered Nurses who were not undertaking academic courses, working with a facilitator who had no experience in the practitioners' clinical areas. This makes it eminently suitable for transfer to a whole variety of other areas where practitioners want to develop their professional learning but want to work with someone from outside their clinical area.

When considering the feasibility of implementing research evidence into practice the key factors that make the difference are the evidence itself; the context it will be introduced in; and how the implementation process is facilitated (PARiHS) (Rycroft-Malone et al., 2004).

## **The Evidence**

The model of a Professional Learning Partnership (PLP) was developed in practice, from actually undertaking the facilitation of learning and then in combination with the practitioners, identifying what we were doing. I believe that the study has been demonstrated as trustworthy, which gives the model credibility for practice.

The Professional Learning Partnership was also named so that there was no confusion about its purpose or intent. The idea is that it can be found on literature searches and will not be discounted on scanning the titles of articles. The words ‘critical’ and ‘supervision’ were deliberately omitted because of their everyday meanings. These leave the model open to misinterpretation, misunderstanding and misuse. It also removes the possibility of the model being confused with any other. The model ‘makes sense’ to practitioners who have seen and worked with it, and for those who might be in the ‘facilitation’ role within the partnership it also appears straightforward and easy to understand.

When considering individual practitioners, the key factors that will make a difference to their willingness to engage with the new model initially, are how easy it is to use, how much time it will take, and is it relevant to them. If they are able to experience the benefits of working with a professional learning partner then I am convinced that they will be assured of its relevance to their practice.

## **The Context**

The initial context for introducing the PLP model will be clinical practice, and in particular with practitioners who are not undertaking academic courses so that it returns to the context that it originates from. The constraints on clinical practice are well documented, however the use of a PLP could be seen in a ‘spend to save’ light. The evidence from this study demonstrates that in an effective PLP, practitioners become more confident, and this leads on to changes in their professional way of being which in turn causes them to change their practice. It also re-energises the practitioners and therefore reduces presenteeism (Rainbow, Steege, 2017). The organisation is likely to benefit from the introduction of the PLP model for these very reasons, but also because small pockets of staff all actively engaged in learning through their work will over time develop into a learning culture.

The experiences from this study suggest that each practitioner would require a 1hr meeting once every 6 weeks. With the possibility of further ad hoc meetings if an active situation is occurring. That is approximately 9 meetings a year and averages out to a total of 3/4hr per practitioner per month.

### **Implementation process**

The first thing to consider would be an awareness raising process with all stakeholders so they know what is planned and can potentially identify staff who may want to be part of a partnership or be a facilitator. A structured Facilitator education process would need to be developed. The literature suggests that this should be a mixture of theory plus experiential learning. The cascade model of implementation has a tendency to become something of ‘Chinese whispers’, and a solid foundation is important for ongoing confident practice. As has been discussed already in this thesis, feeling safe is important for learning and practice, and feeling confident in your competence is an essential part of that. In similar programmes the challenge with introducing Clinical Supervision has always been developing the Clinical Supervisors to get the process started (Goudreau et al., 2015). Similarly, when REACH started, despite putting on an education programme for facilitators, the lack of a ‘facilitation culture’ led to very few facilitators really understanding their role and acting as such. For these reasons the implementation of this work is important. Some areas already have existing facilitated support/learning measures in place and if that is effective then there is no point in changing it, however the facilitators may be a good source of expertise.

With the benefit of the experience gained from undertaking this research I would recommend that the facilitator should be working with their own professional learning partner = 3/4hr/month. They should facilitate no more than 4 practitioners at any one time =  $0.75 \times 4 = 3\text{hrs/month}$ . With their own professional partnership this works out at half a day a month (3.75hrs or one session) to enable them to facilitate 4 practitioners every 6 weeks, and to be in a PLP themselves every 6 weeks.

Each group of one facilitator and 4 learners would require a total of  $3.75+3=$  **6.75hrs / month**. And each ‘Pod’ of 5 facilitators & 16 staff (20 staff would be in a PLP) would require **30hrs / month**.

The implementation plan would start slowly, with ‘Facilitator 1’ working in a PLP with 4 staff (A, B, C, D) who after a period of time (4-6 one-to-one PLP meetings depending on experience) will undertake specific learning around one-to-one facilitation, and straight away take on at least one member of staff in a PLP themselves (up to a maximum of 4).

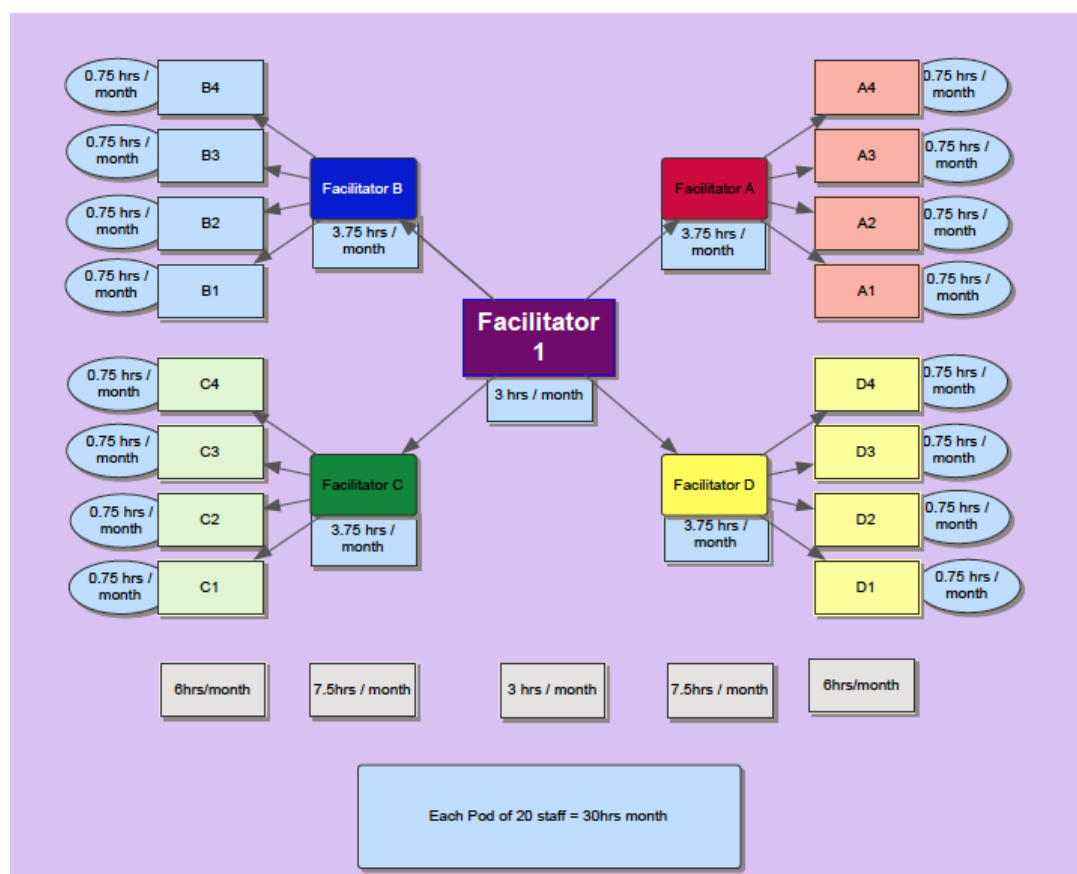


Figure 28-Proposed arrangement for setting up PLPs

Facilitator 1 can then start to work with another 4 staff in one-to-one PLPs in the same manner as the first 4. In this way by the end of 8-12 months we should have 8 facilitators in various stages of development and there should be space for 32 staff to be in a one-to-one PLP. In addition, some of the facilitators from the first cohort may feel ready to take on a lead role and support new facilitators as they learn, which would increase the implementation rate. Staff would be able to choose their PLP so initially this partnering up may start slowly.

Keeping the numbers of staff that each practitioner is working with at 4 enables the process to be manageable for everyone. Each member of staff would need 1hr out of practice every 6 weeks or so to attend their communicative space to meet with their PLP. In this way even a ward with 30 Registered Nurses could still have all of them in a PLP at the cost to the clinical area of no more than 1hr/day. Each facilitator would need on average 1hr/week to enable them to work one-to-one with a practitioner and have their own one-to-one PLP.

### **The added value of introducing the PLP into practice**

Entering a Professional Learning Partnership will not be something that every practitioner wants to do. I suggest however that introducing the Professional Learning Partnership into practice has many potential benefits to the individual practitioners, the clinical area and the organisation. The clinical areas that are being expected to release staff to participate in professional learning partnerships may view the idea of 1:1 partnerships as economically non-viable. In the current climate of reduced CPD budgets however (Health Foundation 2019), an intervention that regularly takes one hour per day out of the ward establishment may be easier to absorb into everyday working, particularly once October 2019 comes and all the ward sisters in Wales become supernumerary. Amongst the other benefits that could be expected are:-

- A. The development of individual facilitation skills fits well with the skills that might be expected of a professional leader and role model, so the development of facilitators can be seen as a good investment for the organisation as a whole. It would also fit well with the leadership work that is about to start with ward sisters and senior nurses.
- B. The personal changes that occur in the individual practitioners who are involved in PLPs is such that they become more actively engaged in their work, thus potentially making them more productive. In addition, the increase in confidence and professionalism leads on to improvements in practice as practitioners are more likely to question both themselves and others. This has benefits for the quality of care and the patient experience.
- C. The secondary outcome of the practitioners feeling valued by being in a PLP is likely to lead to increased staff retention thereby reducing costs and



maintaining staffing levels (Wales NHS Confederation 2017). Having a bespoke method of nurse professional learning also has the potential of making the organisation a good place to work and therefore attractive to newly qualified nurses and nurses wishing to develop their careers further.

- D. This mode of working would also enable staff to produce evidence for their NMC revalidation portfolio where working with a PLP would count as ‘participatory’ learning.

### **Possible other uses for the model in Practice**

I believe that nurses who are undertaking post-reg academic work-based learning modules, up to and including Professional Doctorates, could work with facilitators and use the PLP model. These are generally nurses who are clinically competent but who need space and support to think differently about their practice in order that they can learn and develop both themselves and their practice. Their learning in practice tends to be self-directed, so the support of a PLP would help them to focus their learning and critically consider their practice.

It is worth considering whether the PLP could be used by practice supervisors (Nursing and Midwifery Council., 2018) when they are working with pre-registration nursing students during their clinical practice placements. The NMC has not mandated that supervisors undergo any particular training and has instead left it up to the Approved Education Institutions and their clinical partners to decide what is appropriate (Nursing and Midwifery Council., 2018). Assuming that the practice supervisor is acting in the facilitator role then the model may well be useful in helping student to recognise and realise their professional learning needs. The lack of exposure to registered nurses professional decision-making is something that has been identified as missing from student nurse practice education (Morley, Wilson & McDermott, 2017). This would need testing to understand how it would complement the teaching and supervision of clinical skills and proficiencies, however it may be the key element to pull together a model of practice learning that involves a wide variety of different roles.

## Summary

This chapter has considered the feasibility of using the PLP model in practice, the impact that would have on the practitioners who use it, and the organisation in general. As part of an implementation plan I suggest that the model could be implemented into practice, taking into consideration the requirement for a slow introduction to ensure sustainability. I have also demonstrated that from a practical point of view using the model actively in practice would not make unreasonable time demands on the clinical setting. I believe that the model could also be useful in other forms of work-based learning, in particular for the work-place facilitation of nurses undertaking academic work-based modules, up to and including professional doctorate level. I have also posed a question about practice supervisors using the model as a way of facilitating the learning of pre-registration nursing students during their clinical placements.

I have made some recommendations about research that needs to be undertaken on the model to increase understanding about its potential transferability and other uses. Finally I have suggested that it could be used as a part of a larger study that requires a facilitation model as one of its methods. In my final chapter of this thesis I will draw some conclusions from the research as a whole.

# **Chapter 9 - Conclusions**

## **Introduction**

At the start of this study the organisation was engaged with a work-based learning programme (REACH). What was missing from our knowledge was an understanding of what the facilitator did to enable individual practitioners to successfully engage with the non-academic work-based learning that the programme offered. The aim of this research was therefore to try to fill that gap.

Through undertaking this study, the practitioners and I believe that we have achieved our aim. In this final chapter I intend to draw some conclusions from the study that back up that claim, answer the specific research questions and identify the new knowledge that we have added to the existing literature. I will also make some suggestions for additional research to further develop this work.

## **The Research Aim:-**

To develop a detailed understanding of the role of the facilitator in enabling registered nurses to translate reflective appraisal into work-based learning, and an evaluation of the outcomes of this learning

## **The Research Questions:-**

1. What contextual factors help or hinder work-based learning?
2. What facilitative processes enable meaningful work-based learning?
3. What are the outcomes arising from facilitated work-based learning?

## **The contextual factors that help or hinder work-based learning**

Individual nurses can be affected in different ways by the same workplace context. However, the practitioners in this study identified that the factors that either helped or hindered them to learn through their work were themselves, their managers, their colleagues, and their home life. These relationships all created an environment for the practitioner that influenced how safe they felt in work, and how able they were to do things. Those practitioners who worked in an environment that was the least conducive to learning found that their motivation for their job had decreased over time, along with an increase in their own passivity. These feeling contributed to their inability to act. These practitioners were able to recognise their situation, and because they were still committed to nursing, they wanted to take action to change things, but they didn't know how. Those practitioners who worked in an environment that was more conducive to learning were more active in work, but they recognised their need for outside assistance to help them to learn or to take some changes forward.

Once working with a facilitator, the additional factor that both helped and hindered their learning was the lack of an extrinsic motivator in the form of a formal assessment. For some practitioners this was found to reduce their stress levels and ensured that the learning they undertook was what they wanted to do. It did however lead to some practitioners 'coasting'.

It is the relationships in the workplace that most help or hinder the ability of a nurse to learn in work and develop their practice. Even if there is no effective learning culture, individual practitioners can still engage with meaningful work-based learning if they are given the opportunity and have a facilitator to work with.

## **What facilitative processes enable meaningful work-based learning?**

The practitioners identified that a trusting relationship with the facilitator was essential to enable them to learn. This relationship developed over time, moving from hierarchical to become an adult-adult partnership. The relationship also provided a buffer against stress and anxiety that they encountered in their work.

The facilitator worked with 2 groups of activities to support the nurse to learn. The first group aimed to maintain stability for the nurse by dealing with the immediate issues that were the focus of the practitioners' attention and were potentially standing in the way of their ability to learn. The facilitator was able to provide practical help, channel ideas, make suggestions, and be a sounding board. These activities were felt to enable the practitioner to function effectively in their current role, although used alone were likely to result in single-loop learning. Whilst it is recognised that expert facilitators are able to use the whole of the facilitation continuum to support learners, this is the only framework that makes explicit the need to use facilitation activities from the more technical end of the facilitation continuum as an integral part of facilitation with nurses learning from their practice.

The second group of activities were designed to stimulate the nurse to grow. The practitioner worked with the nurse to unpick their practice, broaden their horizons, change their way of thinking about things, and enable them to take action. These activities required a critical review of their current practice through self-assessment, questioning and discussion. The facilitator also added things to the practitioners' practice in the form of research evidence, reports, ideas, people to contact etc. The fact that the facilitator did not work in the same clinical areas as the practitioners enabled the facilitator to ask naïve questions about the practitioners' practice that led to them being able to see a different perspective. The facilitator also helped the practitioners to make concrete plans for action. The intent with the activities to enable growth was to spend more time working with current and future practice rather than focussing on reflecting on practice that is in the past.

A safe space was needed for the facilitator and the practitioner to interact, which was generally off the clinical floor so that there was privacy and no interruptions. In

keeping with their working environment some nurses were given time for this and some had to use their own time.

The facilitative processes that enable meaningful work-based learning are positioned in a triad. This triad consists of a trusting partnership, activities to maintain stability, and activities to stimulate growth. The triad facilitates understanding, stability, and action, and enables practitioners to learn through building on their current understanding of their work, as well as challenging them to consider their underlying beliefs, assumptions and judgements. The actual facilitation took place through a two-way conversation. A safe space to interact and regular time to meet are important to ensure that more than fire-fighting and single loop learning occurs.

The idea of a triad, and the intentional inclusion in the triad of facilitation activities to maintain stability for the practitioner in their practice is new.

## **What are the outcomes arising from facilitated work-based learning?**

Practitioners who have been working in a facilitated work-based learning partnership have identified that they felt happier and were more self-aware. Their self-esteem and self-belief had increased and they had greater clarity about their roles. Clarity of their own beliefs and values, and congruence between these and their day-to-day work enabled the practitioners to have a sense of direction and feel ‘more at peace’ with where they were and what they were doing.

These personal changes led into changes in their professional way of being. Their increased confidence in themselves enabled them to be more assertive; to start challenging poor practice; to function effectively as a team leader, which included being confident enough not to need to be ‘a friend’, facilitating others to act, and sharing responsibility with their staff. In addition they had a renewed focus on the patient as the clarity about their role developed.

Professionally the increased confidence and ability to think and act differently worked their way through into concrete changes to their practice, with quite a few practitioners

identifying that it was only because they had made changes to their way of being that they were able to take the changes in their practice forward. They almost all identified that one of the key elements of the learning was how to think differently, to do things differently and to be more creative.

These outcomes are significant as they demonstrate that facilitating just one practitioner to learn through her work has an impact on the practitioner as a person. This change in them as a person translates into changes to their professional way of being, which in turn results in changes to practice. These changes appear to be ongoing, as since the study has finished seven of the ten practitioners who participated have had promotions and four have gone on to undertake higher level academic study. Three of the group have also made significant changes to their personal lives that suggests that the improved self-esteem, self-belief and confidence really are a part of them as people. Whilst the general focus for facilitating learning seems to have changed to a preference for working with groups (generally due to constraints of time and money), it is still important to recognise the impact that it can have on an individual practitioner. Throughout our time working together the practitioners were always asking ‘why haven’t I had this before’, and ‘everyone should be able to have this’. They were all able to identify colleagues who ‘needed’ this intervention in order to get back to enjoying nursing again. Whilst attempting to change the culture in an area will always be the ultimate goal, when that is not possible for whatever reason individual nurses can still engage with facilitation to help them to learn and to grow. It is a tragedy that capable women are being left to ‘just tick over in this everyday stuff’ when they could be facilitated to learn and grow.

Working with individual practitioners to support them to learn and grow has far-reaching consequences. The improvement in self-esteem and self-belief transfers into a change in their professional way of being. This change in them as a professional impacts on their practice and their patients. The change in them as people also has knock on effects on their home and family life.

## The Role of the Facilitator

The understandings that I have developed through this research about the role of the facilitator have been synthesised into a new model. We have named this model and the way of working that it illustrates as a Professional Learning Partnership. It is a new contribution to the knowledge around the facilitation of work-based learning.

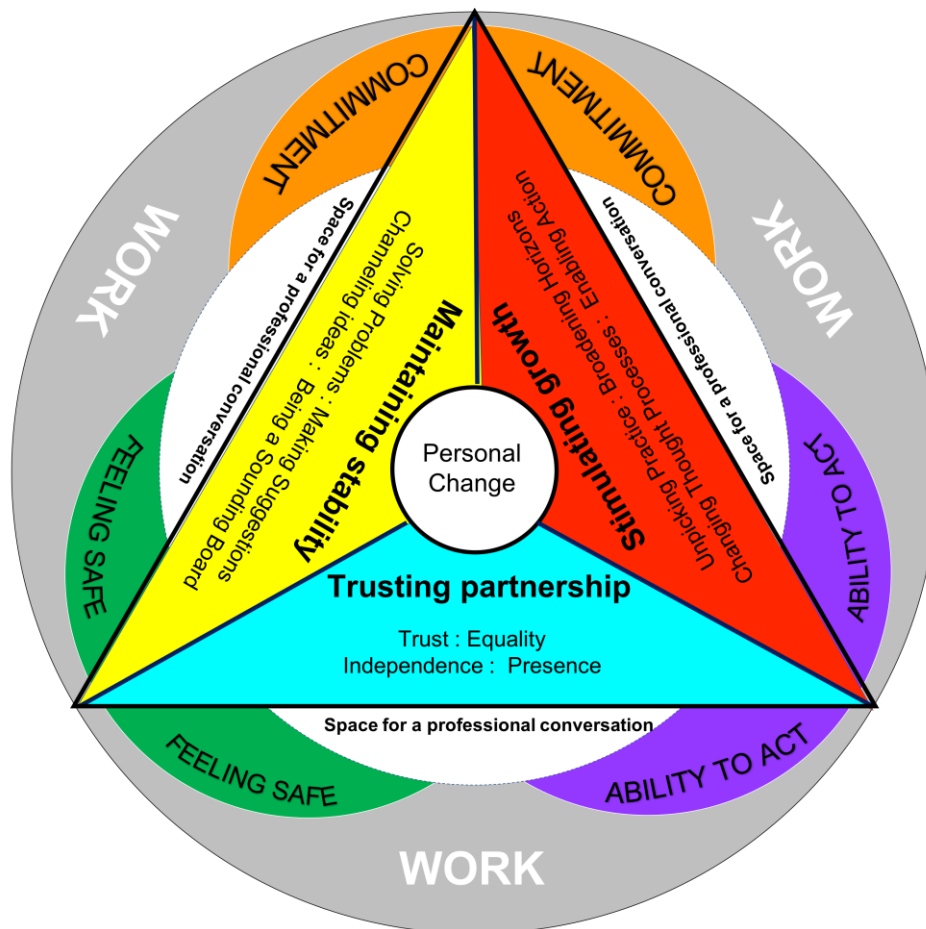


Figure 29: The model to demonstrate the role of the facilitator in work-based learning

The model has been reviewed by a number of the practitioners from the study who all agree that it captures the work that we did together. It has also been seen by practitioners who have not worked with me, and they were able to understand all the elements in the model and could identify with it. The model has also been reviewed



by existing facilitators who were able to see how it could work, and who thought that they would be able to use it quite confidently with minimal instruction.

In designing the model I was mindful of the feedback that I had received from the practitioners during the study about the language that was used, in particular words like ‘critical’ which is always interpreted as criticism. In addition, the model avoids any suggestion of ‘supervision’ as that also implies a hierarchical relationship. The words to describe the activities in the most part used the words that the practitioners had used when describing the activities in the data analysis workshops.

Finally the Professional Learning Partnership was chosen as a title as it explicitly describes what the model is for and should therefore avoid any confusion as to intent.

## **Suggestions for further research**

The model has been developed from practice, but it now needs to be used in practice with a variety of different facilitators and practitioners to determine if it is easy to use, and if it is transferrable to a range of different situations.

The model should be tested to see if it is transferrable in other situation such as with groups, and also to see if it would work as the basis of a peer-to-peer learning relationship.

The model should be tested to determine its suitability for facilitating the learning of pre-registration student nurses

Testing the model with nurses who are men would fill a gap in the original research and determine if there are gender differences in the requirements for the facilitation of work-based learning.

The model could also be used as an integral part of larger studies that require a facilitated learning method.

In developing the model I hypothesised that when working with a practitioner who feels unable to act in work the facilitator will use more of the trusting partnership and stimulating growth activities, whereas if working with a practitioner who feels unsafe in work the facilitator would use more of the trusting partnership and maintaining

stability activities. I coloured the model deliberately with this hypothesis in mind. This hypothesis needs to be tested

## **Summary**

In this final chapter I have answered the research questions and described the contribution to knowledge that I believe I have made. The literature around the facilitation of non-academic work-based learning is quite sparse, and I intend to publish this work so that the model and the Professional Learning Partnership that it represents can benefit other practitioners and facilitators.

The research was carried out using a new methodology that has already been published (Williams & McCormack 2017) and is contributing to the field of person-centred healthcare research.

Personally, undertaking this research has been a life-changing experience. I am really satisfied with the work that the practitioners and I did together, and more than anything else I am proud that I have been able to facilitate these women to regain their enjoyment in a profession that we are all committed to.

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# **Appendix 1: The REACH programme**

## **1A. The Attributes Framework**

# **REACH: A Clinical Career Framework**

## **THE ATTRIBUTES FRAMEWORK**

5<sup>th</sup> Edition March 2008

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Dental Hospital Health and Social Services Trust 2004

Modified with permission for the Welsh context, March 2008.

## **REACH: A Clinical Career Framework**

### **Aims to achieve:**

- Recognition & value of staff regardless of academic or clinical pathway
- Competent and confident clinicians at all levels
- A culture of life-long learning for improved quality of care
- A nursing staff whose skills are transferable throughout the organisation
- Increased recruitment and retention of staff

### **Through:**

1. An effective appraisal process
2. An attribute framework
3. A personal development contract
4. Reflective practice strategy
5. Formal learning opportunities
6. A portfolio of learning, training & development for accreditation

Benner's (1984) model of skill acquisition in clinical nursing practice has been used. It describes how nurses' move through 5 professional stages as their career develops. The newly qualified nurse will begin to work through the clinical career framework after preceptorship. Therefore the point of entry will be at advanced beginner level.

## REACH - The Domains and Attributes:

REACH offers a pathway to lifelong learning to enable you to achieve your maximum potential. The 27 attributes are the core component of your clinical career framework. They have been devised from a series of characteristics or traits that each participant, regardless of level, should aspire to.

The attributes are grouped in to three domains (a) Expertise (b) Practice Development (c) Learning

A.	Expertise	B.	Practice Development	C	Learning
A.1	Communication	B.1	Benchmarking	C.1	Coaching
A.2	Managing the practice setting	B.2	Care partnerships	C.2	Developing Learning Programmes
A.3	Negotiation	B.3	Change agent	C.3	Facilitating learning and development
A.4	Political and strategic awareness	B.4	Complaints	C.4	Giving and receiving feedback
A.5	Role model	B.5	Critical incident Analysis	C.5	Mentor
A.6	Effective Team building	B.6	Evaluating practice and the practice context	C.6	Disseminator
A.7	Time management	B.7	Facilitating reflective Practice		
A.8	Audit	B.8	Networking		
A.9	Person-centred Practice	B.9	Risk assessment and management		
A.10	Practice expertise	B.10	Evidence based Practice		
A.11	Research aware				

## **Personal Development Contract-**

Central to the work-based learning process is negotiation of a learning contract:

**Step 1** - The clinician identifies his/her individual learning needs – the difference between their present level of knowledge and the level they aim to achieve using the attribute framework

**Step 2** – The learning needs are written as learning objectives

**Step 3** - Each learning objective is then considered and a plan is constructed identifying how the individual is planning to achieve the objective

**Step 4** – For each learning objective, the individual describes the evidence that they will produce to indicate their achievement

**Step 5** – Then the individuals state the criteria by which the evidence can be judged

**Step 6** – Review the contract with the Manager– seek the opinions of peers, mentors, facilitators about clarity and relevance of the contract

**Step 7** – Implement the contract – review and adapt as learning proceeds

**Step 8** – Present the evidence in a Portfolio (Knowles, 1990)

## Example

Chris is a Registered Nurse who has been practicing for two years within a clinical specialty area. Chris identified at her appraisal meeting that she was competent with the technical skills required to care for patients within the ward and was working toward a post graduate qualification. Chris feels that she is ready to begin working toward becoming a Team Leader of the ward for which she works and identifies the attributes that she would like to further develop to assist her in becoming a Team Leader.

### Attributes:

Communication and Managing the Practice Setting

### Evidence:

Reflective accounts (diary, action learning records etc) to demonstrate personal development

Thank-you cards from patients and relatives – supported by reflection on the impact of patient care.

Feedback on observation of practice from other staff members

Could have used a number of other attributes

<b>Expertise</b>	<b>Practice Development</b>	<b>Learning</b>
Communication Practice expertise Managing the practice setting Negotiation Role model Effective Team Building Time Management Person-centred Practice	Evaluating practice and the practice context Facilitating reflective Practice Risk assessment and management	Giving and receiving feedback



Example of an Attribute		A.1 Communication		
Relationships with other people depend upon our effectiveness in communicating with them; interpersonal effectiveness has been defined as ‘the degree to which the consequences of your behaviour match your intentions’ Johnson (1978).				
Advanced Beginner		Competent	Proficient	Expert
1.1	Demonstrates understanding of methods of communication	2.1 Have effective verbal/non-verbal communication skills including listening skills	3.1 Role models effective communication with all staff at all levels and grades.	4.1 Ability / potential to communicate at a strategic level
1.2	Is able to reflect on their own communication skills	2.2 Is able to critically reflect on their own communication skills and the impact it has on others	3.2 Role model effective communication at all levels and evaluate effectiveness	4.2 Establishes mechanisms to ensure effective organisational level of communication
1.3	Is able to give example of when different methods of communication should be used	2.3 Demonstrates skills and behaviour that enable others to develop their communication skills	3.3 Ensures the development of essential training provision to maximize effective communication (IT training, advanced communication skills, record keeping etc.)	4.3 Ensures dissemination of information on legislative changes, WAG Health initiatives, white papers, policy changes, national guidelines etc to all staff
1.4	Demonstrates the ability to communicate effectively, both written and verbal	2.4 Assisting others to develop effective communication both written and verbal	3.4 Demonstrates ability to network outside normal sphere of responsibility	4.4 Networks at strategic levels  (Role models / demonstrates excellent leadership skills)
1.5	Demonstrates an awareness of the legal importance of record keeping	2.5 Assist others in developing an awareness of the legal implication of record keeping	3.5 Provide evidence of essential record keeping through audit.	4.5 Acts upon audit results to ensure that standards met maintain and enhanced.

## Example of Part of the Self – Assessment Documentation

Attribute and Definition	Perceived Level of Importance in current practice H. M. L.	Perceived Level of Development AB. C. P. E.	<u>Supporting Statement</u> Give some evidence of why you have placed you self where you are and as an aid – memoir of appraisal
<b>A. Expertise (9 attributes)</b>			
A1. <u>Communication</u> : Relationships with other people depend upon our effectiveness in communicating with them; interpersonal effectiveness has been defined as ‘the degree to which the consequences of your behaviour match your intentions’ Johnson (1978).			
A.2. <u>Managing the Practice Setting</u> : To create and maintain a person-valuing and supportive ethos to enable staff to fulfil their commitment to provide the highest quality of care for patients and (DOH, UK1996)			
A.3 <u>Negotiation</u> : Discussion between two or more parties aimed at resolving incompatible goals (Pruitt and Carneval1993)			
A.4. <u>Political and Strategic Awareness</u> : Translating strategic developments into practice and understanding the process of making health and social care strategies.			
A.5 <u>Role Model</u> : Someone who is regarded as somebody to be looked up to and often as an example to emulate.			

# Appendix 2 – Informed Consent

## 2A. Participant Information Sheet

### PARTICIPANT INFORMATION SHEET FOR STAFF PARTICIPATING IN THE WORK-BASED LEARNING RESEARCH STUDY

**Study title:**     **The role of facilitation in enabling work-based learning**

You are being invited to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take the time to read this information carefully and speak to others about the study if this would help.

Please ask if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

#### **What is the purpose of the study?**

The study is being undertaken as part of a PhD. Its purpose is to develop a detailed understanding of how a facilitator can support practitioners to learn from their work. The study will also look at:-

1.     The factors that help or hinder your work-based learning
2.     The organisational requirements and how we facilitate them in practice.
3.     The impact that your learning has on you, on your patients, and on the organisation.

#### **Why have I been chosen?**

You have been asked to take part because you are a registered nurse involved in the REACH programme within [REDACTED] Health Board.

#### **Do I have to take part?**

Taking part in this study is entirely voluntary. It is up to you to decide. If you choose not to take part this will be respected and will not affect your employment or professional standing in any way. If you do decide to take part you will be asked to sign a consent form before the research begins. You are free to withdraw at any time.

## **What will happen to me if I take part?**

If you decide to take part you will be invited to participate in a programme of work-based learning, working 1:1 with Caroline Williams as your facilitator. The study lasts for 2 years, but your involvement would be for a maximum period of 1 year. As the research is being undertaken as a participatory project, you will also, as a member of the group of participants, take part in the analysis of the data. There will be 5 participants in the study at any one time.

### A. Work-based learning

The work-based learning element of the project will involve:-

- 1) Completing a reflective self-assessment using the REACH framework
- 2) Developing a learning contract
- 3) Undertaking learning through your work to meet the agreed contract
- 4) Developing one aspect of practice related to your learning
- 5) Collecting evidence of your learning and practice development for your professional portfolio

You will be supported throughout this process by Caroline who will be acting as your facilitator. Caroline would meet with you once a fortnight for approximately 2 hours. This meeting would be in your work time, or you would receive time-in-lieu if you had to meet outside your normal contracted hours.

The work-based learning will involve a range of activities which will depend on your identified learning needs. The facilitation techniques Caroline will use to support you through this could include:-

- Observing, listening and questioning
- Feedback on performance
- Role-modelling
- Articulation of craft knowledge
- High challenge / high support
- Use of creative imagination and expression
- Critical dialogue

### B. Data Collection

The data collection element of the project will involve a combination of :-

- 1) Audi-recording the 1:1 facilitation sessions between you and Caroline. The focus is to look at the facilitation techniques used.

- 2) Short informal interviews (5-10 mins) about key moments in your learning. These would occur in the clinical area if you and Caroline have been doing a piece of work together in practice. These would be audio-recorded.
- 3) Creative arts eg. painting, collage. These will be used where appropriate either during your 1:1 meetings or during group meetings, to help you to uncover hidden knowledge. The creative media will be accompanied by either a written or spoken commentary which would be audio recorded.
- 4) Interviews - both prior to the study as well as during and at the end of the study. These would be audio recorded. The aim of the interviews will be to understand the experience from the your perspective, aiming to capture what is important to you; your aspirations; the challenges and difficulties; the opportunities; and what would improve your experience, or what worked well for you.
- 5) At the end of your period of time in the study, reviewing the evidence you have collected in your portfolio

The data collection will take place during your fortnightly facilitation meetings mentioned above.

### C. Data Analysis

The data analysis element of the project will take place at a group meeting with Caroline and the other 4 research participants. You will be fully supported to participate in this process. The knowledge that is generated through this process will inform the future direction of the study.

The group meeting will take place on one full day every 4 months (at the start of your participation in the study and then 3 further times during the period you are involved in the study). This day will be one of your working days. You will be paid travelling money to attend the group meeting if they are held at a different location to your normal place of work.

### **Will my information be kept confidential?**

If you consent to take part in this study, your name will not be disclosed and no personal information will be traced back to you. However, due to the small number of participants in the study it is possible that people closely associated with you or the study may recognise your contribution. You will be able to view and specifically consent to any data that is planned to be used verbatim to illustrate findings within the final research report. You will have the option of choosing a pseudonym or having a pseudonym assigned to you.

All information will be handled, and stored in accordance with the requirements of the Data Protection Act 1998. However, in the interest of patient/client safety, where poor or dangerous practice is identified, you will be supported to raise this with your line manager in order for the appropriate action to be taken.

**What will happen if I agree and then change my mind?**

You can change your mind at anytime and withdraw from the study, and the research team will respect your decision. It would be really helpful to the study if you felt able to give reasons for your withdrawal, but this is not essential.

**What if there is a problem?**

If you have concerns about any aspect of the study you can speak with me, Caroline Williams, and I will try to answer your questions. Alternatively you can contact one of my supervisors (all contact details at the end of this information leaflet). If you remain unhappy and wish to complain formally, you will be provided with relevant information that will enable you to do so.

**What will happen to the results of the research study?**

The results of this study have the potential to provide information on how to effectively facilitate work-based learning. Providing a detailed explanation of the role of the facilitator may help with the effective implementation of facilitation in practice. The findings will be presented in a thesis that will be submitted for examination and then stored in the library at the University of Ulster and in [REDACTED] Health Board. They will also be sent for publication in a professional and/or peer-reviewed journal and/or may be presented at conferences. There will also be local presentations of the research. You will personally receive a written summary of the key findings from the study and have an opportunity to discuss this with Caroline if you wish.

**Who is organising and funding the research?**

This study is being undertaken as part of a PhD programme of study with the University of Ulster. [REDACTED]

**Who has reviewed the study?**

The study has been reviewed by the Institute of Nursing Research / School of Nursing Research Governance Filter Committee at the University of Ulster, Northern Ireland. It has also been reviewed by the [REDACTED] Research Ethics Committee, an independent group of people who aim to protect your safety, rights, wellbeing and dignity. [REDACTED] Health Board R&D approval has also been obtained.

**Further information and contact details**

If you have any queries or would like further information on the study please feel free to contact either me, Caroline Williams, or a member of my supervisory team. Contact details are provided below.

***Names & Addresses Removed***

**Thank you for taking time to read this information.**

## 2B. Consent Form

### CONSENT FORM FOR STAFF PARTICIPATING IN THE WORK-BASED LEARNING RESEARCH STUDY

**Study title:** The role of facilitation in enabling work-based learning

**Name of researcher:** Caroline Williams

Please initial box

1. I confirm that I have read and understand the information sheet dated 6<sup>th</sup> June 2011 (Version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without it affecting my employment or my professional standing in any way.
3. I understand that relevant sections of data collected during the study may be looked at by the researcher's academic supervisors at the University of Ulster and the University of Swansea. I give permission for these individuals to have access to this data.
4. I understand that certain parts of the data may be reported verbatim in the final thesis and subsequent dissemination of the study. I understand that if this data relates to me I will be asked to give specific permission for these parts to be included.
5. I agree to take part in the above study

\_\_\_\_\_  
Name of staff member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**CAROLINE WILLIAMS**

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

# Appendix 3 – Ethical Approvals

## 3A. Research Ethics Committee approval

Rhan o seilwaith ymchwil Cymru a ariannir gan y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd, Llywodraeth Cynulliad Cymru  
Part of the research infrastructure for Wales funded by the National Institute for Social Care and Health Research, Welsh Assembly Government

**NISCHR**

Used  
Cyflym  
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Mrs Caroline Williams  
Learning & Development  
Hafan Derwen  
Parc Dewi Sant  
Carmarthen SA31 3BB

31 August 2011

Dear Mrs Williams

**Study title:** The role of a facilitator in enabling Registered Nurses to translate reflective appraisal into work-based learning, and an evaluation of the outcomes of this learning for the patient, the practitioner and the organisation.

**REC reference:** 11/WA/0209

The Research Ethics Committee reviewed the above application at the meeting held on 24 August 2011. Thank you for attending the meeting to discuss the study.

**Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

**Ethical review of research sites**

NHS Sites  
The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).


**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.


Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.


 **GIG Cymru NHS Wales**  
Bwrdd Iechyd Addysgu Powys  
Powys Teaching Health Board

Cynhelir Cydweithrediad Gwyddor Iechyd Academaidd y Sefydliad Cenedlaethol ar gyfer Ymchwil Gofal Cymdeithasol ac Iechyd gan Fwrdd Addysgu Iechyd Powys  
The National Institute for Social Care and Health Research Academic Health Science Collaboration is hosted by Powys Teaching Health Board

 **Arianir gan Lywodraeth Cymru**  
Funded by Welsh Assembly Government



### 3B. The University Health Board R&D Committee approval

 <b>GIG CYMRU NHS WALES</b> Bwrdd Iechyd Hywel Dda Health Board	<b>Research &amp; Development Department</b> R&D Manager Secondary Care – <a href="mailto:chris.tattersall@wales.nhs.uk">chris.tattersall@wales.nhs.uk</a> R&D Manager Secondary Care – <a href="mailto:barbara.smith@wales.nhs.uk">barbara.smith@wales.nhs.uk</a> R&D Manager Primary Care – <a href="mailto:gareth.davies23@wales.nhs.uk">gareth.davies23@wales.nhs.uk</a> R&D Co-Ordinator – <a href="mailto:alison.armitage-hicks@wales.nhs.uk">alison.armitage-hicks@wales.nhs.uk</a>			
Ref: R&D Approval/aah/Ref: HD/11/020 Date: 06/09/2011	<b>Chris Tattersall</b> <b>Research &amp; Development Manager</b> <b>Withybush General Hospital</b> Fishguard Road Haverfordwest Pembrokeshire SA62 1PZ Tel: 01437 773813			
<b>Caroline Williams</b> Nursing Development Facilitator Hywel Dda Health Board Training and Development Hafan Derwen, Parc Dewi Sant Jobswell Road Carmarthen SA31 3BB	<b>Ysbyty Cyffredinol Llwynhelyg</b> Heol Abergwaun, Hwlfordd, Sir Benfro, SA61 2PZ Rhif Ffôn: 01437 763813			
<b><u>PRIVATE &amp; CONFIDENTIAL</u></b>				
Dear Caroline Williams				
<b>Project Title:</b> <b>R&amp;D Ref:</b> <b>REC Ref:</b>	<b>The Role of Facilitation in Enabling Work-Based Learning</b> <b>HD/11/020</b> <b>11/WA/0209</b>			
Thank you for submitting your proposal to us for approval for the project to be carried out within this Health Board. I have received the comments from the Board review panel and have not received any objections to the project going ahead.				
Please accept this letter as approval for the project to proceed here according to the protocol, as approved by the Research Ethics Committee.				
Under Research Governance, and as lead researcher at this site, you are required to:				
<ol style="list-style-type: none"><li>1. Adhere to the protocol approved by the REC and inform the R&amp;D office of any changes (including changes to the end date of the project) and any changes referred to the Research Ethics Committee(s).</li><li>2. Inform the R&amp;D Office of any relevant adverse/serious adverse events that may occur, whilst also reporting these through the proper channels in the Health Board, and according to the sponsor's protocol and procedures.</li></ol>				
<i>Continued...</i>				
<table border="1"><tr><td data-bbox="359 1574 614 1720"><b>R&amp;D Ref: HD/11/020</b> Pencadlys Bwrdd Iechyd Hywel Dda Llys Myrddin, Lôn Winch, Hwlfordd, Sir Benfro, SA61 1SB Rhif Ffôn: (01437) 771220 Rhif Ffacs: (01437) 771222</td><td data-bbox="630 1574 1204 1720"><b>Hywel Dda Health Board Headquarters</b> Merlins Court, Winch Lane, Haverfordwest, Pembrokeshire, SA61 1SB Tel: (01437) 771220   Fax: (01437) 771222  <i>Bwrdd Iechyd Hywel Dda yw enw gweithredol Bwrdd Iechyd Lleol Hywel Dda</i> <i>Hywel Dda Health Board is the operational name of Hywel Dda Local Health Board</i></td><td data-bbox="1220 1574 1385 1720"><b>1 / 2</b> <b>Cadeirydd / Chairman</b> <b>Mr Chris Martin</b>  <b>Prif Weithredwr /</b> <b>Chief Executive</b> <b>Mr Trevor Purt</b></td></tr></table>		<b>R&amp;D Ref: HD/11/020</b> Pencadlys Bwrdd Iechyd Hywel Dda Llys Myrddin, Lôn Winch, Hwlfordd, Sir Benfro, SA61 1SB Rhif Ffôn: (01437) 771220 Rhif Ffacs: (01437) 771222	<b>Hywel Dda Health Board Headquarters</b> Merlins Court, Winch Lane, Haverfordwest, Pembrokeshire, SA61 1SB Tel: (01437) 771220   Fax: (01437) 771222  <i>Bwrdd Iechyd Hywel Dda yw enw gweithredol Bwrdd Iechyd Lleol Hywel Dda</i> <i>Hywel Dda Health Board is the operational name of Hywel Dda Local Health Board</i>	<b>1 / 2</b> <b>Cadeirydd / Chairman</b> <b>Mr Chris Martin</b>  <b>Prif Weithredwr /</b> <b>Chief Executive</b> <b>Mr Trevor Purt</b>
<b>R&amp;D Ref: HD/11/020</b> Pencadlys Bwrdd Iechyd Hywel Dda Llys Myrddin, Lôn Winch, Hwlfordd, Sir Benfro, SA61 1SB Rhif Ffôn: (01437) 771220 Rhif Ffacs: (01437) 771222	<b>Hywel Dda Health Board Headquarters</b> Merlins Court, Winch Lane, Haverfordwest, Pembrokeshire, SA61 1SB Tel: (01437) 771220   Fax: (01437) 771222  <i>Bwrdd Iechyd Hywel Dda yw enw gweithredol Bwrdd Iechyd Lleol Hywel Dda</i> <i>Hywel Dda Health Board is the operational name of Hywel Dda Local Health Board</i>	<b>1 / 2</b> <b>Cadeirydd / Chairman</b> <b>Mr Chris Martin</b>  <b>Prif Weithredwr /</b> <b>Chief Executive</b> <b>Mr Trevor Purt</b>		

## Appendix 4 – The Meetings

### 4A. Overall list of meetings

COHORT 1											
	P1	P2	P3	P4	P5		P1	P2	P3	P4	P5
	1	1				Week					
						33			10		
Week	2	2				34	14				
Introduction - Nov 11						35					
1	3					36		16			6
2		3	1	1		37					
3	4					38	15				
4				2		39					
5	5	4	2			40					
6						41			11		
7						CRA 2 – Sept 12					
8	6	5	3			43	16	17			
9		7				44					
10			4	3		45			12		
11	7					46					
12		8		4	1	47					
13		9				48					
14	8		5	5		49		18			
15					2	50	17		13		
16		10				51					
17	9					52					
18		11				53					
19			6		3	54		19			7
20	10					55					
21						56	18				
22	11		7	6		57					
23						58					
24		12				59					8
CRA 1 – May 12						CRA 3 - Jan 13					
26	12		8			61	19	20			
27		13		7		62					
28				Dropped out		63			14		
29		14				64					9
30	13				4						
31		15	9								
32					5						

COHORT 2											
	P6	P7	P8	P9	P10		P6	P7	P8	P9	P10
						Week					
						33					
Week						34					
Introduction - May 13						CRA 5 - Jan 14					
1				1		36	4				
2						37				6	
3		1			1	38		6			
4				2		39					
5						40				7	
6		2				41	5				
7					2	42					5
8			1			43					
9						44					
10		3				45				8	6
11						46					
12			2			47					
13			3			48		7			
14						49					
15				3		50					
16						51					
17		Sick			3	52	6				
CRA 4–Sept 13						CRA 6 - May 14					
19											
20											
21	1										
22											
23											
24			x								
25		4	Sick								
26											
27											
28	2			4	4						
29											
30	3	5		5							
31											
32											

## 4B. Example of Meeting Records / Reflective Field Notes

PARTICIPANT:	■	MEETING NUMBER:	4	DATE:	■■■■■
--------------	---	-----------------	---	-------	-------

Descriptive:	What was/ is the experience?
	Write a summary of the experience you are reflecting upon, capturing all the salient points.
	<p>■ started by telling me about her plans for reflecting on her practice.</p> <p>She then discussed work / life balance – her planning has enabled her to have last weekend off completely without feeling guilty.</p> <p>She discussed her work planning that happened at our last meeting – how it has enabled her to have protected clinical time, which is important to her. She recognised that even though her week is now planned this still has to be flexible.</p> <p>This led on to a discussion around a strategic meeting that ■ has to attend tomorrow and issues arising around that. Identified what is within her remit and what is outside. Issues within the team in the hospital that might impact on that.</p> <p>Went back then to discuss our last meeting which in her head she had split into 2 parts</p> <ol style="list-style-type: none"> <li>1. crisis on the phone – how my response to her, giving her some pointers on the phone, then when I told her at our last meeting that I had come to it expecting to have to be hierarchical to get her moving forward, but I found that she had actioned it already and was calm – just telling her this last time made her feel better, that she could do these things herself without needing me to direct her. Stated that she knows that she has the answers in her head, but sometimes needs someone else to tell her she is right. Recognised that she had had to get to the crisis point to enable her to take action.</li> <li>2. our 1:1 meeting – she felt there was a lot for her to action afterwards. Conflicted with her desire for work/life balance. Managed the technical stuff OK, but takes her ages to reflect. Described how she reflects</li> </ol> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p><i>"I can't write a quick reflection. It takes me hours to write that reflection... hours. It's almost like you have to open your brain, and it takes an hour to open your brain. So you write your description of whatever it is you are reflecting upon, and then each section is like cogs going like that (hands make twisting movement) within your brain to open those sections again. And however quickly I try and do it, I can't do it quickly" (18:44)</i></p> </div> <p>Wants some thoughts on how to make it simpler.</p> <p>Discussion on all the reflections that she has planned and how long they will take her. Asked what she was hoping to get from writing the reflections of things that happened 3 months ago now.</p> <ol style="list-style-type: none"> <li>i) Wanted to provide evidence of her progression – feels she has grown a lot but hasn't captured that</li> <li>ii) She then identified that she might be able to capture some of that in a different way. Eg: Described a 'simple' change that she had instigated where the patients 'goals' from the goal setting meeting are added to the nurses handover sheet and how positively this has been received by the ward nurses.</li> </ol> <p>■ discussed the use of a dictaphone and wondered if that would help her to initially capture her thoughts that she could reflect on afterwards – I gave my experiences that often these end up not being listened to, so would she be better just identifying key points from most of her issues. I suggested identifying just 3 key learning points from many of the visits that she had undertaken during her induction period 3 months ago. We discussed the issues that happen when reflections are left to 'pile up'. Becomes a chore, becomes forced, make similar mistakes while waiting to get</p>

a reflection written. Thinks she still has some barriers to reflection. She wants to reflect, feels empowered when she achieves it, recognises the learning that occurs. Recognises that she is a bit out of practice and may get better when she practices. Discussed the use of a journal to jot thoughts in and then identify from all the entries in one week one thing to write a more in depth reflection on.

Identified that reflecting on our meeting may not be the most important thing in her week – could write 3 key points from our meeting and pick something else for the week's reflection. Discussed quality v quantity in reflection. Identified that her reflection that she wrote where she identified that she was comfortable using creativity, and how she then read the article about using collage for clinical supervision and she could see how it linked. So I shared how I will often add to my reflections further thoughts as they occur often many weeks afterwards. We talked about how learning is a spiral, and identified it in her collage from Day 1.

#### Meeting

Moved on to talk about the ward meeting she had had this morning. Identified that she had been nervous as it was important that it 'worked'. Her plans had included it being 'lighthearted,' non-hierarchical and facilitative. Had emailed me last night for warm up ideas. 7 staff attended (3RN & 3 HCSW & 1 OT), one in on day off. She was disappointed at only 7, but I helped her to see that as only 2 turned up for a ward meeting with senior nurse manager only a few weeks previously, that 7 was a good turnout.

Ward meeting warm up – took the ideas I had suggested in response to her email and made the conscious decision to wait until morning to make decision. Recognised that this was a change in her. My question in the email about what was the intent of the meeting made her think about that and identify the appropriate warm up (2 truths & 1 lie). Tried it with some people in the office first and it worked so she used it. Worked well – took away hierarchical approach, felt it identified herself as a 'person'. Throughout meeting identified that priority was the 'person' who has had [clinical condition]. Ward staff identified lots of issues – documentation, structuring the shifts, streamlining their work – she identified that staff were committed, enthusiastic, enjoyed their work, just needed some facilitation to make the changes. ■ was clear that she was not going to provide the issues or solutions that it had to come from staff, and then she was so pleased that it worked! Identified that she is [condition] specific so couldn't do everything they wanted herself, but could give them pointers. Felt that it was good and realistic.

Discussed plans for future meetings – identified that she was only 25hrs and couldn't do it herself so needed staff to take action themselves. I asked how ■ was going to get more staff involved. She recognised that word of mouth would help, making sure future meetings were open to all. Her overall summary of the meeting – a success. I asked her to identify what it was she did that made it a success. She started by identifying the factors that demonstrated it was a success (a HCSW who had been disengaged was now engaged, staff enthusiastic), but when I asked the question again she identified:-

- a) it was a two-way meeting – not her talking all the time
- b) picked out things they were saying rather than telling them – trying to be facilitative
- c) consciously tried to be a facilitator – but recognises could be better
- d) stuck to time
- e) flexible to meet needs of staff not just sticking rigidly to her own agenda

#### Other issues

[Ward sister] had done the patient status board yesterday, and told ■ and they did 'high 5s' (big development from few weeks ago when [sister] complained that they were always being 'told off')

for not doing it). ■ recognises that at moment things are good but knows that things may get worse again. I reminded her of what she said a few meetings ago that staff were non-interested etc. Identified the importance of celebrating achievements

We looked at the challenge / support matrix, and discussed how ■ was using this with ward staff and currently offering more support than challenge but that this was appropriate because they were building relationships. ■ recognises the boundaries of her work, to stay focussed on [her clinical area] and not get swept into the ward issues.

Meeting with her line-manager – cancelled as manager off sick. ■ described how she set limit on arranging meeting to fit within her schedule, felt that line manager was trying to ‘jump on bandwagon’ and claim credit for her development to date.

#### Feedback

Described episodes of positive feedback she had been receiving over the last week “she was making a difference”, Assistant business manager - “things are progressing & she is doing a good job”, Ward staff – “things are lifting since she had been in post”, Speech & language – “improvements in teamwork since her in post as [her clinical area]”. Stated she was obviously a good ‘blagger’ as she didn’t have a clue – I challenged this and she agreed she did have a clue. Asked her how this made her feel – “it feels good”, still not going home happy as still feel lots to do, however feels she deserves her holiday as she has put her heart & soul into work to date.

I offered her feedback that she seemed much more relaxed and accepting that things will change but will take time. Recognised that the positive feedback she received, recognising that the small changes she has made are impacting has made her feel happier. Feels she has given her all, and that that is a major achievement. ■ identified that this week things have come together. I posed the question as to whether this was in part due to her ‘chilling’ a bit – she thought about it and agreed. Felt much better about work in general – feels much calmer in work and at home. Last night – cooked dinner, played with children – that is unusual for her since she took the post. Becoming more aware of limitations of what she can achieve, and how role has changed since leaving [previous clinical area]. Feels that she is achieving her job of being [current post]. States that it is fate that we are working together – that my PhD and her new role were meant to coincide, so we could learn from each other.

I asked her to identify her 3 main learning points from the last few months:

1. She recognises that she is achieving
2. That achieving is long term and not immediate (and she can empathise it now rather than sympathise). That this is only a beginning, and it will take a year to develop the post.
3. “That we do a really good job here” – “we can benchmark against others, but we have to take into consideration our unique situation and recognise that we are doing a good job with the limited resources that we have”.
4. She can identify that over the last 3 months she has changed from being very hierarchical ‘do it this way’, and feels that she is changing as a practitioner and a person, so that she is giving support to others. Feels she is learning all the time, but at a deeper level she is changing.

#### Work to do before next time:

We identified that ■ is actually only working 2 days before our next meeting. So we agreed that she will have a holiday and at our next meeting we will take stock and look at how we go forward.

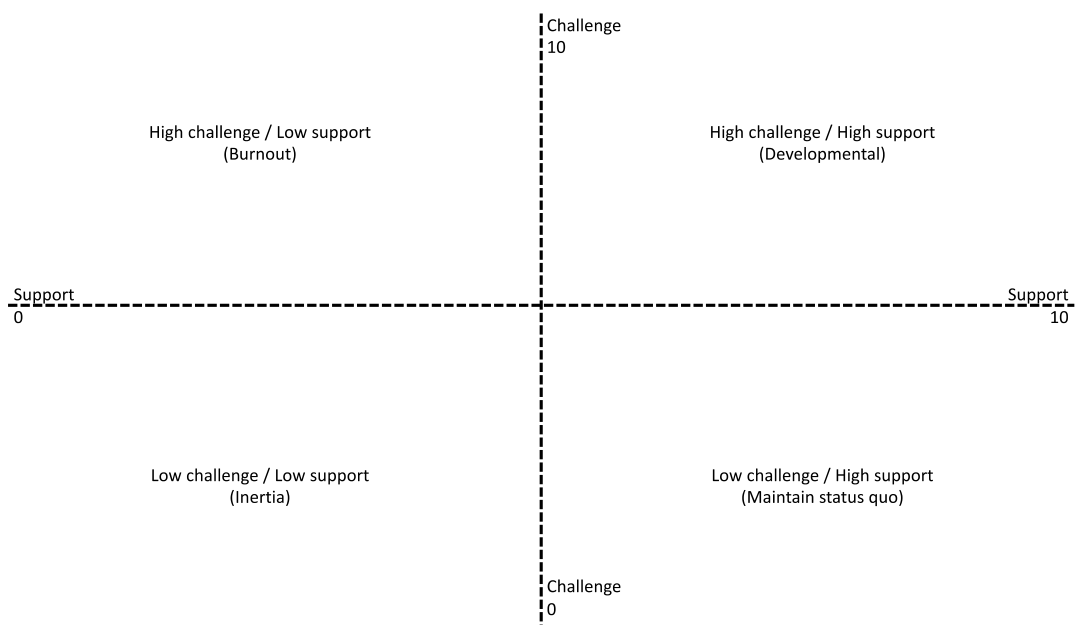
Affective:		What did/ do I feel about the experience?
Consider your own feelings during the experience and those of others involved		
<p>This meeting felt very different to the others we have had. ■ was really relaxed, and had an air of confidence about her. She was able to identify her achievements, recognise her learning and utilise her previous learning to support her current work. Our contribution in the way of talking was probably 90:10 (Her:me), which was a change from the first few meetings where I probably did 30-40% of the talking!</p> <p>I was conscious of trying to get ■ to recognise and articulate her achievements, and to identify why they may have happened. At one point (the 'high 5s' story) I felt myself becoming emotional as this was such a turn around in both ■ view of the ward, and [ward sister] view of her.</p>		
Discriminant:		What options did/ do I have? What factors influence my experience?
Reflect on the various options for action/ non-action you had in the situation and exploring the factors that influenced you taking the action you did/ did not take.		
<p>I felt it was important that we celebrated the achievements and positive events that had happened, as we are all aware that this is a rollercoaster and things may get worse again. So I felt that getting the achievements recorded was important (I gave ■ copy of the recording of our meeting so she has her achievements on record).</p> <p>I was conscious of simply trying to ask questions to draw ■ out, as in the meetings before this one I had been much more directive and hierarchical.</p> <p>I also made the conscious decision to 'give permission' for ■ to take a holiday and do nothing in her time off. I felt it was important that she had a break with no sense of guilt, as she identified herself that she had put her heart and soul into her work since taking up post, and getting a work/life balance had been such a significant part of her learning.</p>		
Conceptual:		How do I make sense of the experience?
Identify the key issues that come out from the discriminant level and looking in more depth at each of these key issues.		
<p>Celebrating success –</p> <p>'Permission' to take a break – why did I feel it necessary to suggest she had a break? Surely this could have been part of her learning to make that decision herself?</p>		
Theoretical:		Analysing the experience in relation to the research questions.
1.	What contextual factors help or hinder the development of work-based learning?	
<p>Order – ■ appears to have started to learn (or at least be able to identify her learning) once her working environment was more organised and she felt more in control.</p>		
2.	What facilitative processes enable meaningful work-based learning?	
<p>Questions – Posing the question by email "what was the intention of her meeting?" enabled her to work with the suggestions in her own way in her own time. Asking the question "what did she do that made the meeting a success?" enabled her to recognise what she had done and how significant that had been.</p> <p>Knowing what is significant to the learner – responding the way I did to the 'high 5s' story; recognising the need for ■ to balance her desire to do lots of written reflections against her need for a work/life balance;</p>		
3.	How are the support and infrastructure needs of work-based learners facilitated in practice?	

Practicalities of writing reflections. How do I help them to do that?	
4.	What are the outcomes arising from facilitated work-based learning?
<p>■ certainly seems to be growing personally and professionally, and she has made a positive start with a ward that appears to be suffering from a lack of leadership and poorly implemented previous top down change.</p>	
Questions:	What questions has this episode raised that I need to explore further?
<p>Is the lack of order and control just something that is specific to ■ as this is her first self-directed post having previously been a staff nurse in a managed unit, or is this a general issue?</p> <p>Is my balance of challenge and support right? Do I need to start being more challenging now that ■ seems to be in a more stable place and our relationship is developed?</p>	
Critical Companionship:	How have I used the framework to guide my facilitation work?
<p>Specific aspects from this session:</p> <p><u>Relationship domain</u> – I feel I demonstrated all four processes in this meeting. I think ■ and I have developed a supportive, non-hierarchical relationship that is mutually beneficial. I feel that I have given ■ support both through the way I have responded to her ‘crises’ and by the way I have celebrated her successes.</p> <p><u>Rational-intuitive domain</u> – Again I think I demonstrated the processes that make up this domain. I was able to identify and celebrate with ■ the seemingly ‘minor’ things that were actually very significant to her and the journey she is on.</p> <p><u>Facilitation domain</u> – In this domain I think I used the processes of consciousness-raising and self-reflection, when I was getting ■ to articulate the things she had done that had made the meeting a success. I feel I need to develop my skills in problematisation, which may link to my recognition that I have not been very challenging. And I also think I did not use the potential opportunity for us to engage in critique when ■ identified that she had deliberately tried to be facilitative in her meeting – so there may have been learning there that both of us missed because of that.</p> <p><u>Facilitative use of self</u> – Although I am consciously aware that I am using certain of the processes and strategies within the framework, I need to be mindful of those I am not using so that I do not become habitualised into using the framework in a certain way all the time.</p>	

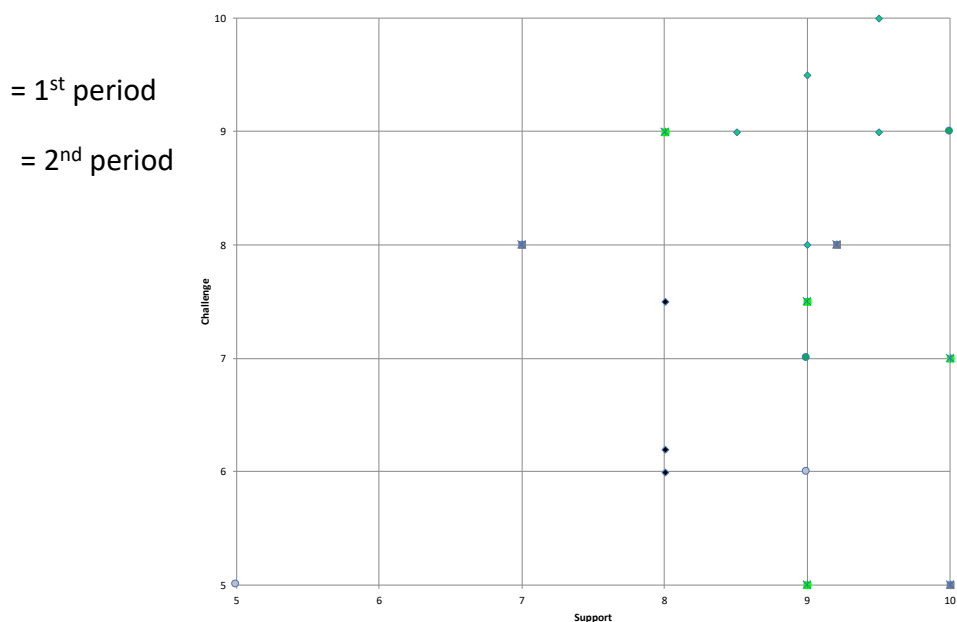


#### 4C. The Challenge and Support Matrix

The challenge and support matrix was used at the end of most of the 1:1 meetings to assess the amount of challenge and support perceived by the practitioners



The amount of challenge increased between the 1:1 sessions of the first period (3 months) and those in the second period demonstrating development in the facilitator.



## Appendix 5 – Creative Reflective Analysis

### 5A. Plan for the workshop

16<sup>th</sup> January 2013

9:30	COFFEE & catching up
9:45	Overview of the day
	<p>What we have been doing together so far is actually ‘living’ the process of facilitated work-based learning. Today the intention is to continue the process of trying to analyse our experiences.</p> <p>So today we are interested in developing shared understandings of our individual experiences; identifying our own role in each part of the process; working out whether what is happening is what we want to happen, and if not why not; and considering what helps or hinders us in taking action.</p> <p>Obviously this is more data, so I will be recording the discussions. Because of that, although I don’t want to stifle discussion it would be helpful if everyone didn’t talk at once (so I might ask you to say each of your points separately if you do!); Also it would be really helpful if you could illustrate what you are saying with examples from your own experience rather than just a “well I think...”. Also remember to talk for yourself and not assume that your experience is the same as everyone else’s. You are therefore in control of what you share and what you decide not to share. If I bring something up that you would rather not talk about then please feel free to say, and we will move on.</p> <p>In the period since the last data day I have done roughly 3 sessions with each of you, so you will hopefully feel in a more ‘equal’ place than I know some of you did last time. That said you are all still doing completely different things, so will have different experiences. It is important therefore that we get everyone’s thoughts and opinions. Also, as last time, if when we are working through this process you want to ask others questions about what they said, then please feel free – this is not meant to be just ‘my show’.</p> <p>Also as before we will have a process review about the whole day at the end, so we can assess the effectiveness of the data analysis method, so jot down any thoughts you have about anything that ought to be changed or that worked well.</p>
10:00	Review terms of engagement
	Put up flipchart from the last day and review terms – pin to wall

<b>10:15</b>	<b>Part 1 – Creative expression</b>
	<p>Create an image of how you are experiencing facilitated WBL, and what do you think are the key issues emerging from your sessions.</p> <p>Things you can think about:</p> <ol style="list-style-type: none"> <li>The Critical Companionship relationship</li> <li>What happens in the sessions</li> <li>What do you take out of the sessions and back to practice</li> <li>How do you make it work in practice</li> </ol> <p>Start from your memories and from the thinking you have done since reading the things you were sent</p> <ol style="list-style-type: none"> <li>the notes of what happened in the sessions</li> <li>the ‘process reviews’ that we record at the end of each session</li> </ol> <p>Rather than just trying to create a picture that captures all the individual issues one by one, try to create something that comes from inside you and involves your thoughts and feelings rather than just ‘facts’ and ‘things’. That way we will pick up on what is really important to each one of you.</p> <p>The key is not to think about it too hard – just create what comes – and remember this is not an art competition, and there is no ‘right’ or ‘wrong’ answer!</p>
<b>11:15</b>	<b>COFFEE</b>
<b>11:30</b>	<b>Part 2 – Discussion of creative work &amp; identification of issues</b>
	<p>Ask each participant to show their picture – and invite other participants to say what:-</p> <ul style="list-style-type: none"> <li>I see ...</li> <li>I feel ...</li> <li>I imagine ...</li> </ul> <p>The participants are not meant to either offer a critique of the artistic value of the work or tell the creator of the work what it means.</p> <p>After all participants have commented on their picture, the creator describes what their picture means, and therefore what the main issues were in relation to the facilitated WBL</p> <p>Write main issues on flipchart</p>

12:00	Part 3 – Unpicking the issues that have arisen
	<p>The issues arising from part 1 are combined / compared with the issues arising from the researcher's preparatory work.</p> <p><b>Creative</b> - The issues identified through the creative work are unpicked using the following three processes</p> <p><b>Dialectic – Developing a shared understanding</b></p> <p>When I was listening to our discussions / looking through our sessions there was an issue that surfaced for me of X ...have we got any shared understanding of what that may be about...?</p> <p><b>Reflexive – Thoughtful, conscious, subjective self-awareness - Exploring self – Self-in-relation-to-others</b></p> <p>Within our 1:1 sessions, how does it work for you?</p> <p>What part do we each play in making this work?</p> <p>When you have identified possible actions you might take, what limits or stops you taking these actions?</p> <p>What stops you telling me that there is something you do not want to do?</p> <p>What enables or encourages you to take the actions?</p> <p><b>Critical – What are you doing with it?</b></p> <p>How do you think you might be able to go beyond those limits?</p>
13:00	<b>LUNCH</b>
13:30	Part 3 – Unpicking the issues that have arisen (cont.)
	<p>Introduce the flow charts with the data from last time, and ask for comments on how things have changed, developed, expanded, no longer apply etc.</p>
14:00	Part 4 – Relating to the research questions
	<p>Having talked through all the issues that we identified from the work we have done together, we now need to look at the research questions, and see if we can relate what we have been discussing to these issues</p> <ol style="list-style-type: none"> <li>1. “What goes on in your practice that helps or hinders your work based learning”</li> <li>2. “What have we been doing in our 1:1 sessions that have really helped?”</li> <li>3. “If you were to identify the key things you have achieved in this period, what are they” <ol style="list-style-type: none"> <li>a. Personal</li> </ol> </li> </ol>

	<ul style="list-style-type: none"> <li>b. The patient</li> <li>c. The organisation</li> </ul>
<b>14:45</b>	<b>TEA</b>
<b>15:00</b>	<b>Part 5 – Doing things differently?</b>
	<p>From your experiences during this year</p> <ul style="list-style-type: none"> <li>a) What have you liked best</li> <li>b) What have you liked least</li> <li>c) What have you learnt?</li> </ul>
	What do you think you are going to do in the next year?
	From your experiences over this last year, is there anything that you think I should do differently next time?
<b>15.30</b>	<b>Summary / Process review</b>
	<ul style="list-style-type: none"> <li>1. In this day, what have been the best and the worst bits for you?</li> <li>2. Have you found it easy or hard to participate?</li> <li>3. Did you feel ‘obliged’ or pressured to agree with others, to say something nice, to not criticise etc, or do you feel you have been able to get across your true feelings about facilitated WBL?</li> <li>4. Do you think that we have done what we set out to do ie. analyse the process so far of our facilitated WBL?</li> <li>5. Have you learnt anything new from today that you think will affect the way you approach your WBL in the future?</li> </ul>
<b>15:45</b>	<b>CLOSE</b>

## 5B. Examples of Creative Work done during the Creative Reflective Analysis Workshops



### Emma – CRA 3

Emma – Yes...well basically the initial idea was that...I think the things that I wanted to achieve most while I am in this facilitated learning was to develop myself in my role, and develop my learning, because I was in a new role, there was lots to do. And I think without the trampoline there is a certain amount of blocks...it I imagined I had to build something, there is a certain amount of blocks that I could have just built on my own, because I could reach them and they were easy....but if I ..sorry Caroline....if I imagined Caroline as a trampoline...sort of lifting me to new

heights so that I could build on what I already had, and reach new things and keep adding and adding...so it doesn't necessarily have to come to an end...I can just keep adding new building blocks. And like in your (Melanie) picture you said that it is the little things that make the difference...it's like individually those blocks are all just little things, but together you can build something...you can build a wall...you can build whatever you want to build really, just by working on the little things. So some of them are not glittery and they are just little projects, and then other things were a bit more important and that is why they are sparkly. But yes it is a positive picture...there are lots of colours...I didn't want to do just like a brown wall because it just feels more multifaceted than that, it feels like there is more to it than just one thing...everything that I...all the little things that I may not even really realise that I have learnt or developed...are more than just plain old bricks...they just...they are more important than that. [...]...I might have to do a bit of climbing instead...but yes, I think that is the idea that even after our relationship...you know the end of this year together...that I have started something that I can keep building on ... and you have given me the sort of basis to do that.. with the ideas...how to unpick things.. how to sit and talk to somebody about it even if it's not you, then to sound off with someone else. [...] Yes...so there was a lot of learning and developing to be done

Me – And I like the idea that you said you could have built a lot of it on your own...

Emma– Yes.... although it took a while for me to realise that...that actually I had quite a lot of those building blocks in place already...that although it was a new role I have brought those with me....and it took a while for me to realise that didn't it...that I hadn't lost the skills I had developed in the previous 9 or 10 years, it was just a matter of rejigging them

### **Key words**

Achievement, support, channelling

### **Bethan – CRA 4**

Bethan –So in the beginning I thought what is all of this... but eventually after speaking to you then we came out with 3 (attributes) that I thought I could work on. And what I realised as I was doing this was that they were actually one... because each one of them I looked at – facilitated learning, person-centred care and leadership – and they are all actually interlinked and everything moves forward. Whereas in the beginning I was really questioning, what is this all about, and I was quite



negative about myself when I did the self-assessment, but after Caroline's feedback I felt really positive and I thought oh my god I'm actually doing this. And it's not something said Oh tomorrow I'm going to do that, but I was actually slowly doing it, even though, with a lot of encouragement from Caroline to take things forward. I am not that sort of person, but I can see, from bringing things forward then, it's not only.... those sort of smiley faces are not only the staff but the patients as well, because everything is person-centred care, which everything stems from for the patient, but you have actually got to think of your staff as well as people and what they need. So one of the things we looked at is PDRs that I am... I have never done. But how positive they are. Because it's like appreciating that every member of staff, no matter what grade they are, wants to develop at some point so that they can move on....so that they can go off and do....it's recognising their potential as much as recognising my own. So I have just...I just feel a lot more positive about things...and things are continually rotating from here. Does that make sense?

Me – Yes it makes sense. OK some key issues then



Bethan – Issues..... I have got from that is that everything is **person-centred**. From patient to staff team....so its recognising everyone as an **individual**. I think everybody wants to develop, everybody. And I think what I have learned, even though... I don't know if I discussed it with you...that no matter what grade, people do get frustrated, and they do want to move on... and I think it is valuing the other people and recognising that there might be something that they want to do as well. So it's that. And I think leadership wise in the beginning... I think I said this to Caroline in the feedback that we have...I thought leadership was like a certain type of person or something you said like "tomorrow I'm going to....", but you actually do it slowly. It doesn't have to be standing on a pedestal....it's just guiding people along with standards and things. [...] The main thing I wanted to say is that I have actually come out much more **positive**. That I am an individual, and I might not do things the same way as everyone else.. but it doesn't necessarily mean that its wrong...no

### Eve – CRA 6

Eve – I think when I first came on this .... I felt I needed to conquer the world...everything was wrong and I was never going to change everything....



One man can't change everything... I think that is what you have helped me to do...these little glittery bits are just you and what you have helped me to do...you have helped me to focus on things, um...you have given me guidance on people and links to make,

and ways to make systems work better... and just that bit of support and guidance to free up a bit of time as well in work...we have made some changes that ...for the better...even though they are little things, like our filing our paperwork... things like that...that has actually now taken a positive thing and put the effort into turning them into practice, and now we have got more time to go out and do our visits rather than replicating work and ...just... I felt very dysfunctional at the start, and almost like a dysfunctional cog in the system... but now I am finding a way of slotting in and getting things to work together and ...with your guidance, and a lot of pushing, and telling me to focus on things



and .... At the end of each session as well....you know you get the points of things of what you should be doing... I find them really helpful actually to know .. you know what, I am not going to focus on that, I am going to do these one or two specific things and then you feel like you are getting somewhere and making progress. [3:42]

Me – So key words?

Eve – I think **focussing** for me...on one task and not one hundred and one million jobs... and also **support**... and **networking**...because I never would have thought of looking on Twitter for support and things like this...

Gwen – Uh?

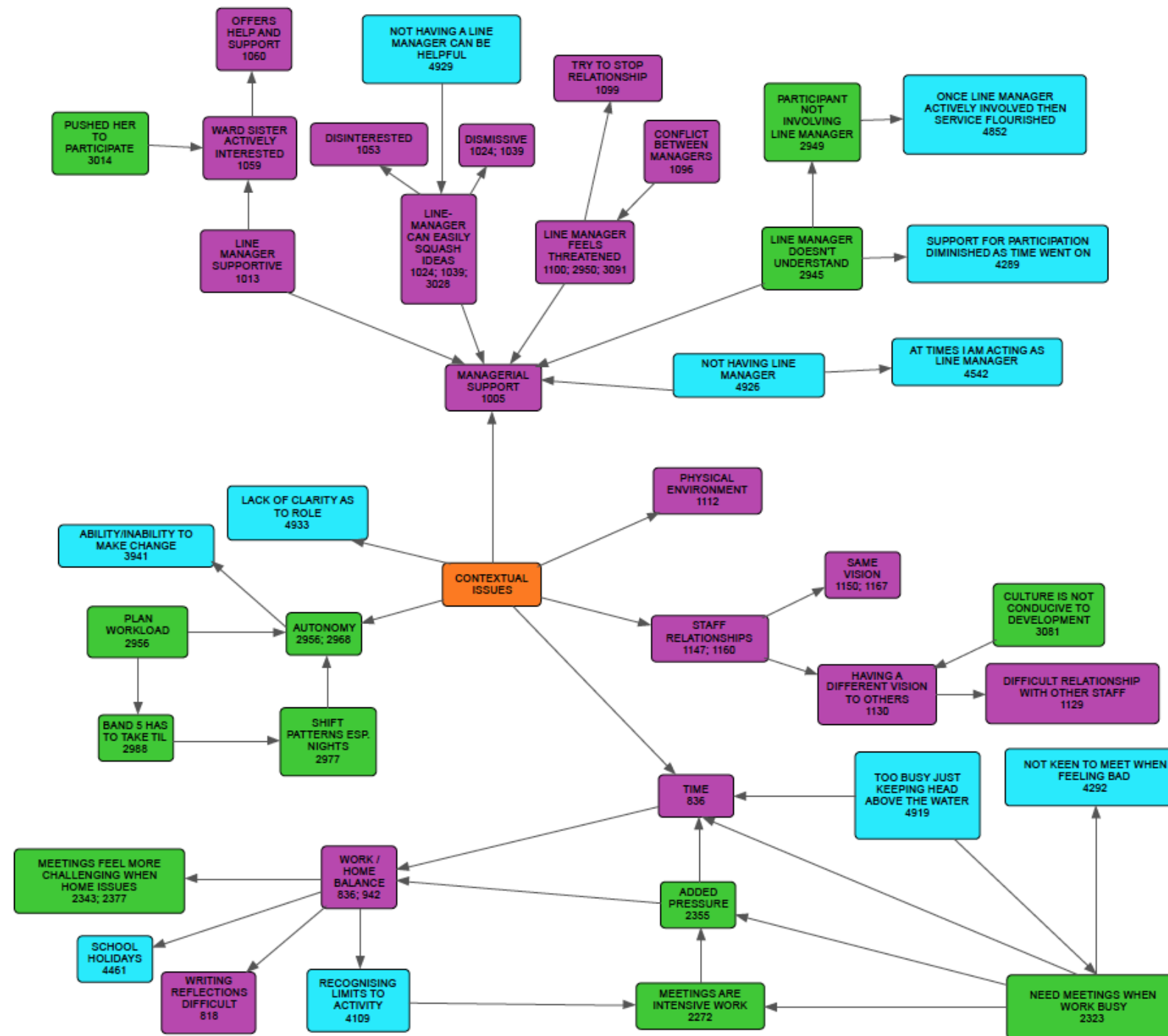
Eve – Yes for groups and things...this one is a wealth of knowledge

## 5C. Key issues identified from the Creative Work

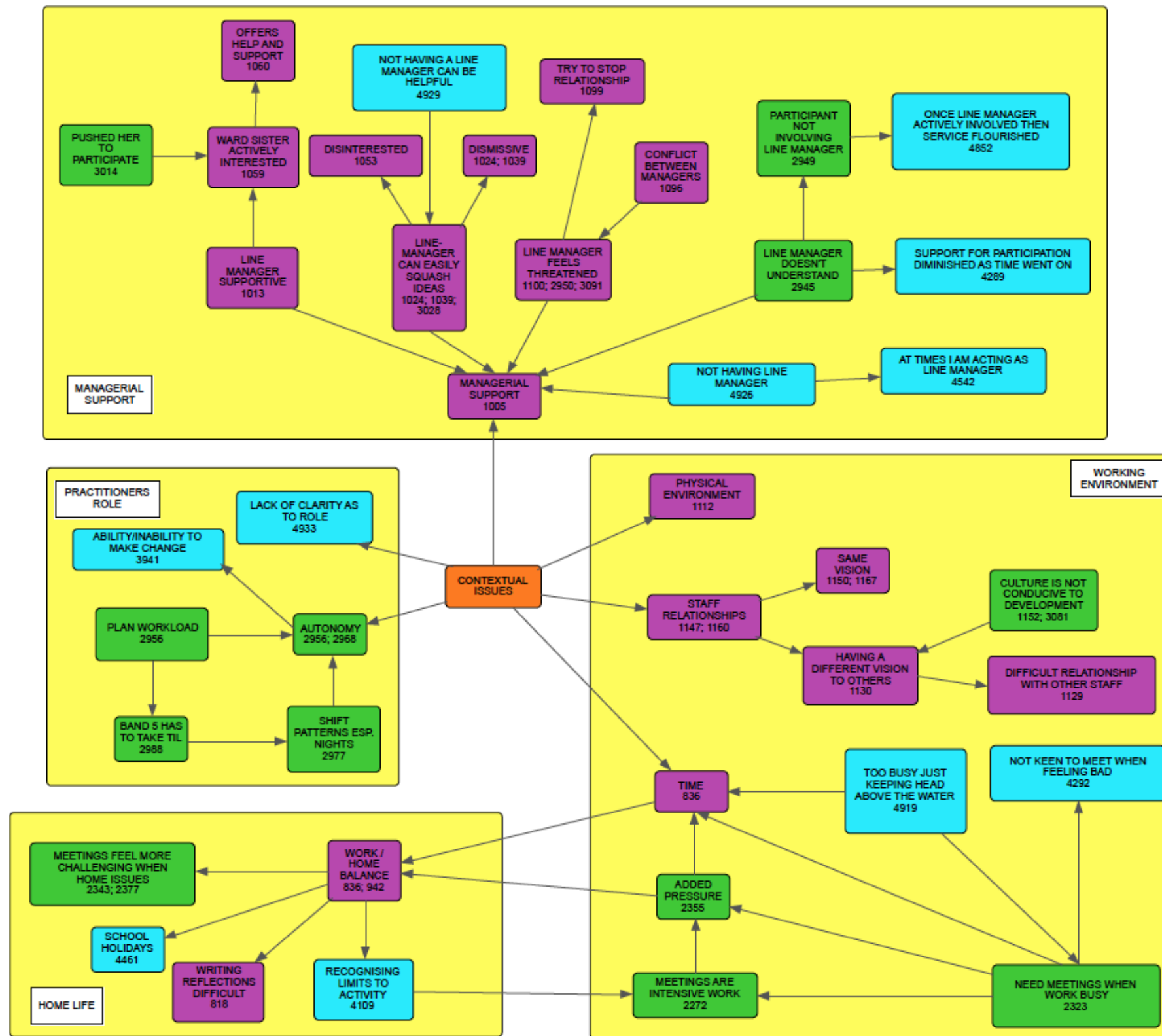
Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
Equality Partnership	Equality / balance		Person- centred Individualised	Individualised	Time to think
Support	Support always available	Support Reassurance	Put things in perspective	Constant support	Support / guidance
Ongoing		Life-long			Ongoing and fluid
Enthusiasm	Inspiration	Realism	Positive		
Open doors	Guidance	Eye-opening		Networking	Network
Clarity	Organisation	Channelling – organising / structuring	Stability Structure	Direction / clarity	Focus
Opening mind to criticism	Challenging self and others	Questioning constructive and reflective	Reflection on HOW	Tying in knowledge to practice	Thinking outside the box
					Looking at things in a different way
Confidence	Developing confidence on our own	Serenity Holistic	Confidence	More self- aware Acceptance	Content / acceptance
Personal growth	Holistic growth – personal & professional	Growth Achievement	Belief in self	Grown as a person	Belief
Professional growth	Satisfaction and achievement	Positive affirmation	Golden nuggets	Regain enjoyment in my work	Satisfaction and achievement
	Spreading WBL to others	Developing others			

## Appendix 6 – Thematic Analysis

### 6A. Mapping uncovered issues (Cohort 1)



## 6B. Theming the data (cohort 1)



## 6C. Rationalising the elements and sub-themes

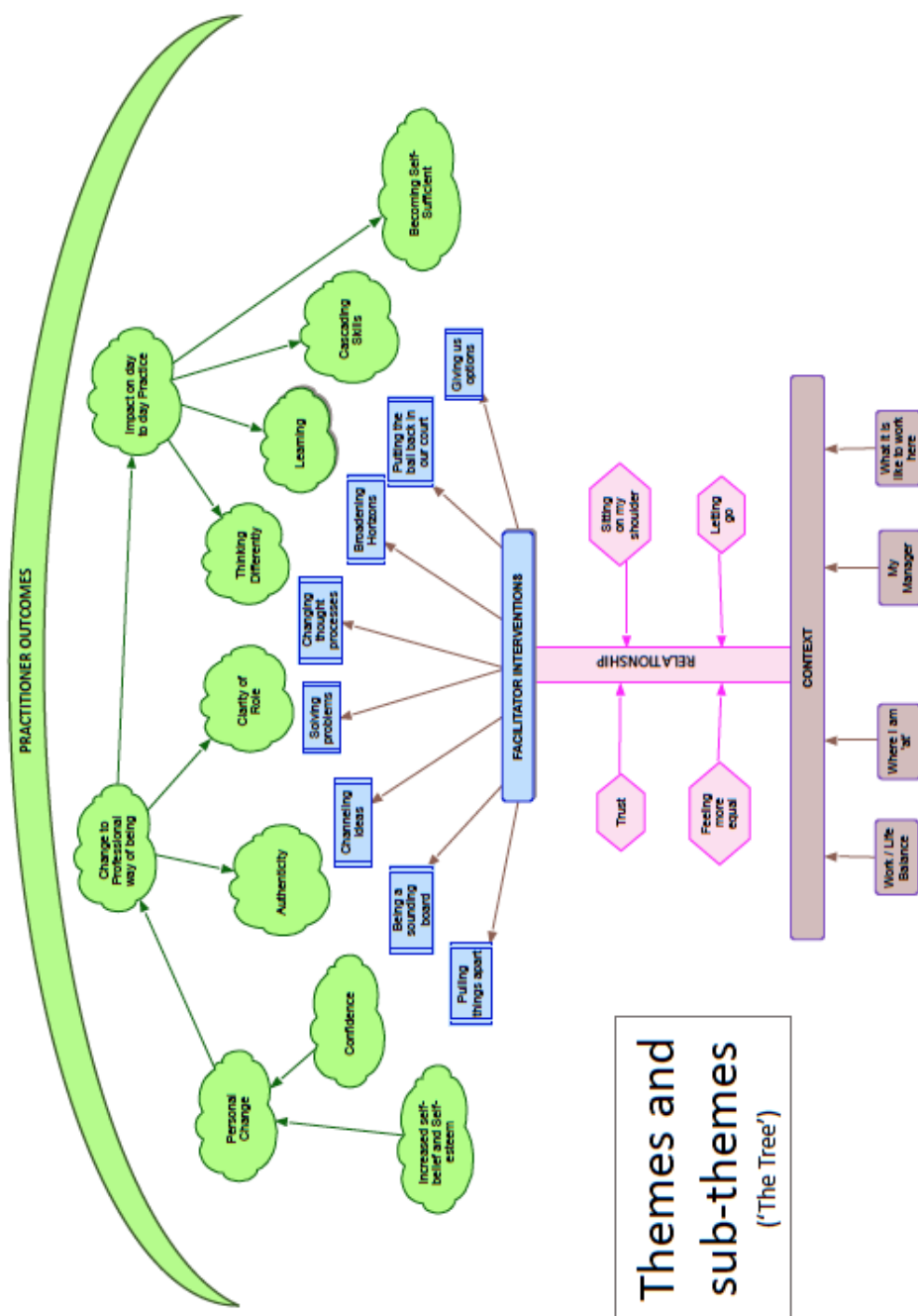
Brief extract of this phase of data analysis. (Cohort 1 & 2)

THEME IDEAS	Other ideas	Name	Extract	
WHERE I'M AT	A PURPOSE	LL	I think it runs alongside what we do, isn't it...and I feel really everybody should be able to tap into a similar system, because I am sure there are loads of people out there with tons of potential who are so drummed down by work..	6362
		LL	I think the people who come here are already aspiring in a way. You are already in a place where you want to change... those are the people that are coming to you anyway... we all came here with a purpose... we were all either lost or we wanted it to change or something... we are not just your normal	7692
		LL	– If I am being honest it was my manager that pushed me to do it....because I had no idea about this beforehand...that was why the focus was on the [...], because that was how it was delivered to me....or ...you know....would you like to do this because it will help you to deliver the[...] concept....and that was why in the beginning it was all about [...]....because in my head that was what it was all about... and it wasn't until afterwards...and I think that is why at the beginning I was so lost about ...you know... your.... after a couple of meetings I actually realised... Oh... OK... this isn't just about [...] at all X – Its about me! Y – Absolutely yes.... and it took me a while to realise that...but at the same time, it has helped with both... you helped me to develop and you have helped the [...] project...even though there has been like a blip because we didn't have anybody at the time... so yes, yes	3014
		LL	and she knew that I was peeved off basically... she knew I wasn't happy with what I was doing... just ticking over day by day. So she said to me "look I know this lady that will help you, and SHE said "Caroline helped me get a portfolio together, really questioned my work and what I wanted to do", that sort of thing... so she will be a really good experience. I thought 'sod it, I've got nothing to loose", do you know what I mean. Its just if anything can happen, if anything good can come out of it, then great. So that's why...	7704
		LL	Because people get lost along the way with ... like something I said earlier on... you go home and you can be so negative about yourself... I am not doing this or I'm not doing that, or I am not going anywhere... losing direction...	8962
		LL	I think I was very lost... because obviously I had had a lot of moves from ward 7 to the stroke ward.. and I just felt...god I am just plodding on... I just felt frustrated... so when I got offered this... because [...] had done it previously ... She said...Oh I think this will be good for you... and I was like...Oh I have got nothing to loose, I'll give it a bash sort of thing... but I don't know if I had been a couple of years previously if I would have gone for it... and you do though don't you if you are stuck in a rut and things..	9237

THEME IDEAS	Other ideas	Name	Extract	
	SELF DIRECTED	MM	And I think when the seas become stormy again, which they will, and when we are challenged again in our Role for whatever reason. If you were still being there as our work-based facilitator, I think we would probably up the intensity of our meetings again, depending on the need. I don't know, I might be wrong...	4310
		MM	I always feel before you come..."oh my god what am I going to talk to Caroline about today because I haven't done anything"... and that you will probably think "oh why are you doing this"... but then after we have spoken I realise that there are things that have been going on...yes...so there are things going on...and I do think about it quite a bit afterwards them...and I am quite motivated...and then I forget	6351
		MM	if my Critical Companion had been say like the ward sister or some sort of manager, you would feel like you would be trying to impress them or you would feel a lot more under pressure, and its not like that working the way that we work, which is just whatever happens, happens. Try to forge a bit of direction, but its not pressured I don't think	526
		MM	But there is a balance between seeing this whole experience as ...."Oh god I have got to do that".....and being relaxed enough not to do it	4489
		MM	Now that...where it says no pressure..I think that links in with what we were saying before when we were talking about how challenging things were...because if you don't feel under any pressure, how can you be challenged. I think in the beginning I didn't feel as challenged as I could have...I didn't feel any pressure...so I wonder if the two are linked...because I would imagine you would need a certain amount of pressure now ....but maybe challenge and pressure are quite different I don't know...to give you a bit of a kick up the bum...because I remember saying to you in the beginning...what happens if I don't get this done...nothing happens ... there is no....	4595
		MM	It makes no difference if um.....we do what we have discussed in our sessions...it makes no difference to anyone but ourselves...and that was why I was questioning whether I have taken my foot of the gas a bit and become a bit complacent, and not pushed myself any more to go back to read my notes and take out ....write notes on top of my notes and say right these are the action points I am going to do, this is what I am going to do....you know...so have I become a bit complacent.. has the pressure ... but that is my pressure, that is not Caroline's challenge	4607
		MM	if its too regular, I don't think you would have that... I don't think it would be too much of a support or challenging...it would just be... it has to be done	9106
		MM	I tend to beat myself up and think I should have done more in the last 6 month, but really, when I look at what I have achieved in the last year, then I don't think I have a right to beat myself up, because yes there was a lot for me to do in the first 6 months outside of my role, but that was... well linking into my role... but that was very important to be in the place where I am now.I think... and I couldn't have continued at that level otherwise I would have burnt myself out...	4106

THEME IDEAS	Other ideas	Name	Extract	
		MM	because I think that reflective work and clinical supervision and facilitation and development takes up brain power and sometimes I can feel overwhelmed by using that brain in there that has to remember so many things all the time..... To have that constant challenge even with support...it can't be a continuous level of how high it felt when I first started working with you..... because ...I don't think it would be sustainable	2271
WHAT IT'S LIKE TO WORK HERE	MAKING CHANGES	KK	Its just like opening a can of worms (attempting change)	4806
		KK	I think that with myself on the ward, I had so many fingers in so many ponds, there was so many things that I was interested in .... And you want to change the world don't you... You can see things going wrong all the time... But you made me realise that you can't change everything in one go, and you are better off just focussing on one thing. so getting a bit of a focus rather than focus on everything, focussing on what I can do	7176
		KK	I like her and I get on with her well, and as a friend she has been very helpful, but I don't know that she .....I don't know that she is that supportive of..... because when I or we have had ideas in a session I have taken them back to her and she has sort of...."do we really need that", and I am thinking "O no we probably don't" ...so just leave it there...if she hasn't done it in the last 10 years it can't be that important"	1021
		KK	you don't get any allocated time for making a difference... you know if you want to do.... You know when I was doing ...cascading oral care bundles and stuff... everything that I did for that oral care health promotion board thing, was my own time, my own work...and I was even having to go in to put it up on the wall in my own time. You don't get anything back from your ward manager, so you almost feel, what's the point... because...	7316
		KK	You have got your work constraints for one, because you can't allocate the time... you don't get any allocated time for making a difference...	7312
		KK	everything we wanted to do....if you hadn't known [...] and she agreed to some stuff....then it would have been hard. You know I have got loads of ideas and things I want to do, but unless you have got supportive managers there is no point having them"	3028
		KK	You know like as a band 5 I didn't feel as if i had much power, and you know, like dementia patients and standards of care with them... So Caroline said, start a ripple in a pond effect. Change the way that I work so that other people can witness it, even just the healthcare assistants, and getting other people on board to make those changes in a different way, so rather than them say "we are ticking forms today and we are doing it because some audit is coming up" so she said if you see it as a problem with the way some people are communicating with dementia patients, then perhaps by you practicing good things other people will turn more and make the change and things like that [...]	7179

## 6D. Revised concept map – the tree





## Appendix 7 – The Findings

### 7A. Theme 2 – Practitioner / Facilitator Relationship

#### 1. “Feeling more equal” - Emma

In the creative work undertaken at the start of the first data analysis workshop two of the practitioners captured both the developing relationship and the subsequent changing dynamics.



**Emma** - “I think also with that (the painting) I tried to make it sort of equal, because our meetings now are more equal. We go there now and we chat together, whereas in the beginning I probably felt like you wanted certain things from me. I felt like you were expecting certain things from me, and you were in charge of the meeting. And now I feel that we are more just there together, supporting each other in a way. [...] It feels more equal. That black part in there (the centre of the spiral) was actually meant to symbolise a sort of border between you and me, in the beginning. But then it stopped. So that was you doing your job, and I was there as the sort of guinea pig. And now it doesn’t feel so much like that, now there is more equality (CRA 1712)

## 2. “Feeling more equal” - Melanie



**Melanie** - “Well it is meant to start at the bottom and work up. So that is sort of the progression of my relationship (with Caroline). [...] I felt that she was supporting me. So the child on the hip is very much that Caroline is holding me up [...]. And when I first started in my role, which coincided with working with Caroline, I very much felt that. And then during the journey so far [...] we have climbed some stairs with regards to our relationship, but also my development. And then the second picture is of an older child, still being supported, but standing on its own two feet. And there is respect there that was built in our relationship. And then we climb up some more stairs, [...], although there is respect and there is equality in our relationship, I have still got so much more to learn. So by no means is that the end of the cycle [...]. (CRA 224)

### 3.Relationships and Boundaries (Williams, 2012a, Williams, 2012b)



When undertaking some reflective work about the issue of relationships and boundaries I painted some pictures that actually captured what I felt was my current situation, with no boundaries between me and the practitioners.

“In this image there is a much greater degree of blending, which I feel implies a more supportive relationship with much greater shared learning between all. However large parts of me seem to be obscured. Is this significant? Does it actually make me less available to work with the practitioners?” (Reflective diary)

I went on to discuss my reflection with one of my academic supervisors, who helped me to put things into perspective.

“The issue [...] is the facilitator or supervisor needing clear boundaries about what is in the relationship and what is outside the relationship. It is not so much the relationship domain per se, in terms of the authentic connection you may have with the person, but it is about what is legitimate to focus on, and what is not”. (BMcC)

Following on from this work I was able to re-position my view of the relationship as being more purposeful.

## 7B. Theme 3 - Facilitation Activities

### Using Challenge and Support

#### Example 2 – “Someone to say it as it is” (C19)

Catrin had been seconded to work in a new area, where she was jointly ‘in charge’ with a Clinical Nurse Specialist (CNS). The idea was that one practitioner would contribute clinical expertise and the other would contribute management expertise. In the event this was not working well, partly because of the completely different ‘style’ of the two practitioners. As Catrin described to me the difficulties, which included the relationship between her and the CNS, I felt there was a need to challenge her, but as can be seen, I was hesitant. Catrin was aware that I needed to say something, so prompted me

Caroline – you...

Catrin – go on...

Caroline – You sound very..... hard done by?

Catrin – I am not hard done by, but I have got a lot to do. I have got a lot more to do than she has

Caroline – So what are you going to do about it?

Catrin – I can’t do anything about it.

And Catrin went on to explain why she felt she couldn’t do anything

Caroline - OK. So have you done anything pro-active, beyond feel sorry for yourself (said with a laugh) [...]

Catrin – No, I am just doing *my* job.

It was obvious that Catrin had talked herself into a victim mode, so I felt it was important to try to shake her out of it by helping her to articulate exactly what her professional responsibilities were. As I asked the question I also repeated Catrin’s answer, firstly to show that I was listening, but also as an emphasis so that she could

hear her answers said back to her. As can be seen this strategy worked and I didn't actually have to finish the last question.

Caroline – Are you responsible for this ward?

Catrin – Jointly with CNS

Caroline – So you have a responsibility for this ward. And if the CNS decided to sit in the office all day and put her feet up and do nothing, how much of the ward would you be responsible for?

Catrin – All of it

Caroline – All of it. And what is your whole aim of being here? Why are you here? What's the point?

Catrin – to make sure that we maintain the standards, to make sure that the patients are safe

Caroline – OK. So then look at these two, no three incidents. [...] They are just three things that you have told me about. Who is at risk?

Catrin – Patients

Caroline – So the longer that you sit back and say, "well it's not my responsibility, she was asked to do it..."

Catrin – I know, well that isn't exactly what I meant (and she started to laugh).

Having 'broken' the block, we were then able to work out a plan of action together as to what Catrin was going to do to move the situation forward. This extract demonstrates both the importance of being able to deliver a challenge when required, and also the benefits of knowing the person you are working with - Injecting a laugh was a risky strategy - however in this situation it was effective. In the process review at the end of the session Catrin marked the challenge as 10/10, but she also marked the support as 10/10. She went on to explain

"You have challenged me loads on things I didn't want to be challenged on, but knew I needed to be. But then as always you give me lots of sensible advice. Sometimes I just don't see it when I just think things over, and it just gets all mixed up and I end up thinking really irrationally. Sometimes you just need someone to say it as it is"

### **Example 3 – “Getting me to do something I should have done” (K9)**

Melanie still hadn't shared the feedback from the patient satisfaction survey. The feedback had been collected from patients on the ward that Melanie had significant concerns about, and this was therefore an essential bit of information that the ward staff needed to try to improve their practice.

Caroline – Have you spoken to either (Band 6 or 7) about the feedback?

Melanie – No. Well a little bit but not .... I saw (Band 7) last week [...] and I mentioned to her then that there were certain things within the patient satisfaction survey that had highlighted some really good practice, but also some practice that we need to look at together. So she is aware that there are some things that... but I am more than aware that there are some things that I need to go and sit and talk to them about.

Caroline – Because I don't know who else has seen these patient satisfaction surveys, but you have had them for a long time now

Melanie – Yes, I need to do something about them

Caroline – Yes, because all the while you are sitting on them doing nothing...

Melanie – Things aren't changing

Caroline – Yes

In this instance the challenge was effective and during the process review in the following meeting she told me what she had done

Melanie – do you know what I did following that challenge? [...] First thing Wednesday morning I went to Audit and picked up the patient satisfaction surveys and the first job I did on Wednesday morning was I went to (Ward Band 7 & 6) [...] and I shared it with them. [...] And I kept pushing on the fact that there were some very good things in there, but there were some things we need to work on, and it was a good little session. (K10)

#### **Example 4 – “I still can’t believe that I am good at nursing” (J6)**

I was talking to Jade about an upcoming job that she was going to apply for. This wasn’t designed to be interview preparation, however when I realised how difficult it was for Jade to talk about herself I pursued the topic because I felt that it was important for her to be able to talk about herself in a positive fashion during any interview.

Caroline – So why do you want the job?

After some difficulty Jade went on to explain how she had worked hard, had done lots of courses and was doing the job already. Jade recognised that this was not a ‘good’ reason, but appeared stuck so I asked her a different question that required her to actually assess her own practice.

Caroline – Do you think you would be any good at it?

Jade thought she would be good at it, and went on to list a variety of reasons why – most of which were preceded by the word ‘I think’. She then said that she had been ‘moulded’ to become a Band 6 for a long time now, which she attributed to

“my enthusiasm. I know that I love my work. And I do know that I am a good staff nurse, and I know that. And I think because I like to think of myself as a good role model, and I think other people see me like that as well. [...]

It was apparent that Jade was finding it very difficult to think and talk about herself, so I suggested that she do some preparatory work for her interview by answering these three questions.

- What qualities have got that actually make people identify you as having potential?
- Why do you actually want the job?
- Why would you be good at it?

Jade responded with a very emotional statement about herself and her nursing

Do you know what, I have never actually thought about why I want the job, because I have always, as I said, been moulded and then it was expected of me. [...] And now you asked the question. [...] In a kind of way I still can’t believe it in my head that I am ‘good’ at nursing. I don’t know if that makes sense. But then when I am having to actually say I am good at it –wow – do you know what I mean?

Other people can tell me, but it's hard for me to say it. And now I am going to cry!

### **Example 5 – Challenge & support – “stepping over the fence” (K1)**

Bethan was having difficulty in identifying herself as anything more than an advanced beginner in the attribute of being a ‘role model’, yet I was fairly sure, having listened to her talk about her work, that she was functioning at a more advanced level than that of advanced beginner. In addition, knowing that one of her main issues was a lack of confidence I wanted to boost this by enabling Bethan to realise just what she did do on a day-to-day basis. So I started by getting her to describe to me someone whom she thought of as a team leader.

Caroline - Describe for me what a team leader is like? Not what you would like to be or anything like that, just what you think a team leader is.

Bethan described her ideal team leader

Caroline - So that is your description of a professional team leader role model. Do you differ from that?

Bethan initially thought she was different to what she had described, and ran through how she thought she measured up. She identified a couple of minor areas where she felt she wasn't ‘performing’ as she ought, and then realised “I think yes, probably I do fit it” – and she laughed. I then ran through some of the attributes in the REACH framework and after each one asked her if she did that. She replied yes to every one, and I then pointed out that they were all from the competent level. We then had a discussion about those technical skills that Bethan needed to develop (eg. doing the off duty).

The second part of the conversation developed from Bethan's response to this discussion when she said that she didn't see herself as any different to anyone else in the team, and if someone else had the skills then she was happy to let them do it. We went on to talk about the difference between a Band 5 and a Band 6.

Caroline - “It is difficult the step from a Band 5 to a Band 6, and the people who struggle as a Band 6 are the ones who do not ‘step over the fence’”.



Bethan – I think that is the struggle I have been having. I was never out looking for a Band 6 post, it's just that the previous senior nurse told me to go for it as she felt that I should. And it just happened. I just sort of slid into it.

I then offered Bethan quite a heavy challenge. The challenge was directly picking up on what Bethan said, and was using my own experiences of staff difficulties when making the transition between a Band 5 and a Band 6.

Caroline - Well a perfectly blunt statement is if you don't want to take that management line and that leadership responsibility and all the rest of it, then you need to go back to being a Band 5.

Bethan – I realise that now Caroline, and I think that is the difficulty I have had. I thought I was being fair, and I realise I didn't take a step back, and some people have taken advantage of it, and I have allowed that to happen to be perfectly honest with you.

## **Giving us Options**

### **Example 7 – “Yes, I like that idea” (J2)**

Following on from our discussions in our first meeting about person-centred care, and from Jade's desire to work with this attribute I thought that Jade could use a more 'person-centred' way of gathering information from staff. I suggested this and we discussed the possibility of using focus groups rather than a questionnaire.

Jade – yes that is a good idea because they will bounce off each other then. Because sometimes what you see when you ask people questions they know what they should be doing, but what they are actually doing.... It's that honesty thing isn't it. It's getting people to actually be honest. I think I am going to write that there now – speak to (the CNS)[...]

Caroline – and depending on which angle you are coming at this from will depend on whether it will 'fit better' with what you are trying to do. Because if what you are trying to do is [...] support patients in a dignified way so that they haven't go a flashy light thing over their head “This person has dementia”. That you are trying to do it in a person-centred way – that actually the gathering of information beforehand from your staff in a person-centred way so you come up with quotes and things, might be a better fit than boiling them down to numbers. So 85% thought this and 55% said that.

Jade – [...] That doesn't give you much does it.

Caroline – And you have lost the person. Whereas if you are able to say we did some focus groups with a group of HCSW and a group of registered nurses and these were their discussions, these were their views. So you are not naming them, but they are still more identifiable as people rather than just a number.

Jade – yes I like that idea. That is much more me. I really do like that and I might suggest it to (the CNS).

### **Example 8 – “Just something on paper” (G4)**

Gwen was keen to undertake some further education around palliative care. She wanted to do a module from the Palliative Care degree programme to validate her knowledge. I suggested that she could develop her own learning programme instead that might actually be more beneficial for her.

Caroline – So what would be the benefit of doing the learning by yourself rather than going on a course?

Gwen – Because I could pick what I wanted to look at rather than be told what I had to do. [...]

Caroline – Because there certainly wouldn't be anything stopping you compiling your own little programme, collating your evidence in a portfolio and putting it in for APEL.

Gwen – Yes I could do that then couldn't I

Caroline – You could start off by identifying what specific skills you need and really focus it on what you are interested in doing and work that way. You might actually cover a broader subject area that met your need, than just writing one assignment.

Gwen – yes that is true. What I might do as well is pick one of the Macmillan nurses and see if they have any thoughts of what we could improve on. What areas we could develop to help them, so that we can work better together. Not that we don't work well together now because we do, but there are some things that could be improved.

## **“Channelling ideas”**

### **Example 9 – “tackling this thing in completely the wrong way” (H1)**

Helen’s initial thoughts around the project were just too big and too complex, and this was effectively paralysing her from taking any further action and stopped her from recognising the work she had already done. Through our conversation Helen was able to narrow down her focus to something that she could realistically ‘take on’, bearing in mind her role as a full-time Band 5 Staff Nurse

The key actions that I took in this were trying to make her think broader around the topic, picking a focus and then narrowing down into that specific area.

Caroline - The next one – assess for the use of inhalers – demonstrated and understood

Helen – That is a good one because I have actually had pharmacy come out and look at patients and they were given a spacer, and then they come up and monitor them. So that was good.

Knowing the context of the ward (a lot of nurses new to the speciality), I had something in mind, but wanted to encourage Helen to think for herself, so I asked her the question

So is there anything else you could do around this?

But when she just looked a bit blank I made the suggestion about assessing the nurses’ knowledge as well, and not just the patients. Once I had done that, Helen was immediately able to see the relevance of it and I used the recognition that this was a potential focus, and linked it with something that she told me she had learnt in the past week to illustrate why this might be a relevant topic for this ward at this moment in time.

Caroline – [...] Because think what you learnt the other day about nebulisers and oxygen. Are you the only person on this ward that didn’t know that?

Helen – No, because I have already helped others out with that as well. A lot of us on this ward are from different medical backgrounds. Because when Ward x closed a lot of girls were redeployed here, but their backgrounds are stroke and CCU rather than respiratory, so they are not as au fait with all of this. And we

have a lot of people leaving at the moment so it is a very green workforce and we do need the training.

This focus into a relevant small area freed Helen up to start thinking of practical applications, which I was then able to encourage. My purpose in doing this was to ensure that she was working with her own plan and not just implementing something I had suggested.

Caroline – OK, so tell me more about that then

Helen – Well what we just said – inhaler technique – I could get some training in that and then hold project workshops with some inhalers and a pharmacist and make sure everyone knows how to do it and then they watch the patient's do it. [...]

Having helped Helen to focus from the large and complex into one small and manageable area she was then able to do the same thing with another aspect of the project and ended up with two areas of focus that she could plan for and take forward.

## **“Being a sounding board”**

### **Example 10 – “Its been nice to voice my concerns” (F7)**

Eve had been complained about by another CNS. The complaint was that Eve, who despite being new in post was not inexperienced, was overstepping her role boundaries. At our meeting a few days later Eve wanted to talk about this and explained the whole situation.

Eve - I did think Oh god, have I overstepped the mark, should I be doing things, should I just be going in and doing an [intervention] and getting out? But I thought no, it's about what is right for the patient isn't it. So I came home on Friday - I have not had anyone say to me you are doing your job wrong in my whole career, no-one has really brought me down to make me feel that bad - and I felt quite deflated coming home

My questions were designed to help Eve think through the process, and to help her to rationalise what had happened and where she wanted it to end. I am also mindful that this is not support for the practitioner at all costs, but it is about helping the practitioner to really think through the implications of the event and their actions. So in this instance my key questions to Eve were:-

Have you looked at your job description?

Have you got a meeting arranged?

Do you think the patients get confused by two of you going in and potentially saying different things?

So what do you want to do about it?

Having thought about the initial complaint, the possible reasons behind the complaint, Eve's way of working and its impact on patients, I helped her to bring it to a 'holding space' where she could deposit her anxiety about the issue. The aim behind this was to enable her to continue to work well in her role until the meeting between both practitioners and their line-managers would hopefully bring it to a resolution.

Caroline - OK. So you know why you do what you do, and you are happy with what you do.

Eve – Yes I am now. I did look back over my notes just to reassure myself and I thought, no, I am. I am going to stick by my guns. I am happy with what I have done

Caroline – Are you going to change anything?

Eve – Not for the time being, no. For the time being I will carry on [...] so long as I am doing right by the patients. [...]

Caroline – And are you sure you are not confusing your patients?

Eve – I don't think so no. While I am there I am pretty diplomatic.

The benefit of this intervention to the practitioner was summarised by Eve during the process review for this meeting.

Eve – I think for me it's just been nice to voice my concerns and everything today, because I have just been so stressed over the weekend. I can't stand anything like this, so it's just been helpful just to revoice it. And for you to make me feel yes, I am doing it for the right reasons. Because that is what I tell myself and then its like 'omg ....'. Its very easy to get pressurised by - not management - but other people and things that are already set up in their jobs. And I'm quite new and I'm thinking like, omg I don't want to have a hard time. [...]

### **Example 11 – “Clarified what I thought and what I had done” (G3)**

Gwen had raised concerns about a nurse who was bullying another member of staff. Despite her previous experience in a more senior role she still found that the incident caused her considerable anxiety.

Gwen – When I was talking to Band 7 about what was going on, I knew what should be done, but obviously I am not in any situation that I could do anything about it, so you have got to hand it on. And I did have a bit of a conversation with myself about it - should I speak to her about it, should I, in effect, break a confidence and tell the Band 7, or should I just keep quiet and see what happens. But I think the, not the managerial head, but the more sister head said no its got to be sorted otherwise its going to cause huge problems within the team. Whereas one of the other girls may have said ‘oh god its nothing to do with me’. [...] I did think to myself, am I just carrying tales now? But it just really bothered me. And I don’t think it is just carrying tales I think it is something that needs sorting out because if she has done it twice to two different people then there is the likelihood its going to happen again., and again, and again

My approach in this instance, knowing Gwen’s previous experience to have a discussion about the possible options. This worked effectively for Gwen who commented in the process review that

“I think that clarified what I thought and what I had done [...]. And I think when you talk to someone outside a situation you can get things more clearly set in your mind. Whereas sometimes I think you are a bit muddled and you think 'oh god, have I done the right thing, and should I have done this". But I think when you have talked it through with someone who is not in the situation then it clarifies everything”

### **Example 12 - “I want to make sure we get it all right” (K8)**

Melanie wanted ‘advice’ about a patient she was involved with. The management of the patient had become nurse-led, and she recognised that in order to be person-centred there needed to be an element of ‘risk-taking’, and it was this that was causing her some disquiet.

Melanie - I think this is the first time I have ever had to deal with a situation like this, so I am not sure whether I am going with my own gut instincts on how to deal with it and my own previous experience,

but I just want to make sure that we get it all right really, that it is the right thing for him, and the right thing to do. Half of me feels like ‘that’s his home and he needs to go back there’, and we can’t make decisions about where he goes back to, but he needs to be safe. [...]

Caroline – I don’t really have an easy answer for you. But my question is “Whose life is it?”

Melanie – It’s his life

Caroline – And I suppose it comes down to that difficult thing where, what is the alternative? And is the alternative more for the patient’s benefit, or is it for the staff’s benefit?

Melanie – Yes. My gut feeling is that the patient wants to be at home with his wife, regardless. If that means that it’s not a ‘safe’ discharge in the OTs and Physio’s eyes, then it’s still what he wants. He wants to go home. And I could see the disappointment in his face when I said that we had cancelled his discharge. But he understood why, but I could just see that he was gutted. So he does understand what I am saying, but he can’t communicate back to me what he wants.

Melanie went on to describe some of the issues that were causing her and the rest of the MDT team some concerns. My next comment was designed to be provocative in an effort to focus the discussion. This strategy worked and Melanie ‘nailed her colours to the mast’ and identified what her next step would be.

Caroline – Yes. And the comfortable thing and the easy thing is to say well we will keep him here then until we can put him in a nursing home, where someone else can provide all the appropriate technical care. Because then we can tick the box, feel better and absolve ourselves of any worry.

Melanie – But it’s not what they want. And that wouldn’t be ticking a box because I know it would kill the patient, because he would hate to go anywhere else but home. But what I don’t agree with, what I feel we can do more with, is about the home situation before he goes home. [...] So I think there is a compromise here that we need to make.

Once this decision had been reached the next part of the conversation became more about helping Melanie to think about some of the actions she needed to take to ensure her ‘risk taking’ was safe.

## **“Pulling things apart”**

### **Example 13 – “thinking about the way I work” (A2)**

We had started out considering patient feedback, but by picking up the subtleties and nuances in Annie’s answers I was able to turn the discussion to what really mattered in Annie’s practise:-

Me – I wondered how much do you actually go and see the patients and their families while they are in-patients?

Annie – I try to go as much as I can, I do try to go as much as I can. Maybe not as much as I should [...]

Me – So what do you say to them when you go to see them? What is the purpose? Why do you go to see them?

Annie – To see if they are OK. To see if everything is going OK with them. How are they getting on? How do they feel they are getting on? Is there anything that is worrying them? Things like that - just generally chat really [...]

Me – I was interested in you saying, “You don’t see them as much as perhaps you **should**”

Annie – Not as long then, I’ll go in and it may be just 2 or 3 minutes, and I’ll just flit by really.

Me – OK. So "flitting by". What sort of information are you going to get?

Annie – Not a lot [...]

Me – So it is just to think, why are you going to see that patient?

Annie – I know **why** I should be going to see the patient.

Me – Ah ha! So why should you be going to see the patient?

Annie – Make sure they are OK, and that everything is OK with their care and they are progressing OK, and if there are any problems I need to address them, and if they are unhappy just to let everyone know. [...] I know that is **why** I should be doing it, but sometimes I feel as if I **have** to do it. I don’t want that to sound nasty, but if I am not seen on the ward everyone wants to know where I am.

Me – So we come back to exactly the same thing as we started this morning with - are you doing this for the person that is the patient, or are you doing it to tick the box?



Annie – I suppose if I am honest - and I will be honest - I suppose I am doing it to keep people happy on the ward.

Me – And who are you keeping happy?

Annie – The nursing staff (laughs), and not the patient, and it should be the patient shouldn't it.

#### **Example 14 – “recognising my own learning” (E7)**

I suggested that Emma ought to record this as learning, and worked through the CPD template showing her how she could complete it.

Caroline – So did you get that down on the form that records your Continuing Professional Development?

Emma – No. Because I sat there this morning and I thought, I don't really know what to write

Caroline – OK, so tell me what learning activity did you do the other night?

Emma – reading up on (drug) in pregnancy and DVTs in pregnancy [...]

Caroline – What did you read, and where did you get the information from?

Emma – Internet [...] But various web sites really, because that is all I had access to at home.

Caroline – Why did you do it?

Emma – Because I wanted to be able to give (the patient) accurate information in an area where I wasn't that au fait

Caroline –[...] Was the reading adequate for what you needed to do?

In a previous session Emma had also mentioned giving a woman contraceptive advice, so I drew her attention to this, and we discussed another couple of patients who Emma had been involved with, and she also mentioned the Doctor that they can refer patients on to for sexual health matters.

Caroline – So you have actually got a nice little package of learning that you have achieved.

Emma – Have I?

Caroline – Yes, you have. The thought of having to go and counsel that women who had just given birth made you do your bit of reading

around (the drug) and pregnancy, you have gone up to see them and they have given you the questions that has taken you down a little route, where you have to go and find out the issue of the (drug) and (an alternative drug) and are they the same. And the issue then of not getting pregnant in those 6 months when they have transferred onto (drug). But that then has led you on to the fact that actually you may have to give contraceptive advice for other patients, [...] and how au fait are you with possible alternative methods of contraception besides the pill.

Emma – Yes, because all I have ever said to patients is basically while you are on (drug) you can't fall pregnant. But apart from that one girl, and the one girl yesterday, I have never had to go on to say about anything to do with contraception. So that was interesting. [...]

Caroline – So can you see you can fill in the front of that [template] on some learning that you have done, and then you may end up with a lot of these (the back of the template) where you have actually put that learning into practice. So you may do that work on Contraception, and you might see 6 or 7 different patients with different questions, different needs, and you could write something for each patient putting this learning into practice

Emma – I am going to have to write this down because you know I'll forget. Because something that this Dr fed back to me in that phone call is, [...]

Caroline – So actually that is your learning as well – that telephone conversation with the Dr [...]

Emma – So pregnancy v (drug), so I can do one on the reading up that I did, and what it led onto was the (drug) v (alternative drug)

Caroline – Which you are going to do some more learning on, because you are going to talk to Band 7

Emma – yes now, because that is sort of new to me. And contraception.

Caroline - So can you see then that these might all be different front pages of the learning that you have done, and you could have no end of these second pages describing how you have put that learning into action. So you have described to me a couple of different patients that you have seen with various contraceptive issues, so you might have one front page on some learning that you have done on contraception and then you might have a few of these over time of different patients that you have seen that are all just adding different aspects

Emma – to the same learning

Caroline – or how you have put that learning into practice. So this patient here she asked me these questions and I didn't know so I had to go back and do more questions. The next patient I saw, when she

asked me some questions I knew the answers. So its building itself up into, this is some learning and how it affects my practice around looking after patients who are pregnant or who have recently given birth and how it impacts on them. And that then links to your patients that are of childbearing age and additional counselling that need to give to those patients [...]

## **“Broaden our horizons”**

### **Example 15 – “You don’t know what is out there” (F1)**

Eve was really frustrated at the communication skills of the HCSW when bathing patients with cognitive impairments.

Eve – Quite a few times I have found that staff on that ward, their communication skills when we have got a confused patient who is aggressive and things like that, they go in there with a “We’re going to wash you” attitude, “we’re going to do this”. They don’t explain very well sometimes and they are often met with a lot of scrambling or pinching or what have you. [...] With confused patients, I think they are more than happy to leave them, rather than actually get spat at or..

Caroline – I have a friend who works in Southern Ireland in an EMI unit and she has actually been doing some work around bed bathing and things like that. And how if you go about it the right way it's a nice experience. And I’m wondering if she might have anything that she can send us that would be helpful.

Eve – Yes. For example a typical little lady yesterday with dementia. “Do you want a bath?” “No” “Oh she doesn’t want a bath”. I said, “if you ask her all day she will say ‘no’. If you ask her does she want a drink, she will say ‘no’. If you ask her anything she will tell you ‘no’. That is just what she is like”. But if you go over to her, at her level, proper communication skills, hold her hand and ‘I’m so and so, I’ve come to look after you today’, she’s more than compliant and she’ll stand with you and allow you to do everything. But there are Healthcare Assistants shredded to bits because they have gone in, in pairs “for backup”. This poor little old lady is lying in bed petrified, not knowing where she is, can’t remember who anyone is, doesn’t even know her family’s names, so I am not surprised she is...

Caroline – So how much education and information is given to staff about caring for patients with dementia?

Eve – They had the butterfly scheme introduced [...]. So this lady has a butterfly above her bed, all the paperwork filled in, but they are still approaching her with an “Oh god, she’s going to scam us.” “Don’t get her out of bed”. “Why can’t she get out of bed?” “Oh because she won’t stand”. Yet she stood perfectly fine for me. And I don’t know if it is because I have been in hospital myself – ill – and I think you see it from a different perspective. And I think some of these haven’t. But if you are lying in bed ill and somebody approaches you and is going to give you an injection, like a Clexane or something, and you are not sure why or... I’d lash out. Its normal. Its normal behaviour for her situation. As for education for them, I don’t know what they have had, but it’s a major problem.

Caroline – So X, what role does she have? [1:06:54]

Eve – Well, now she came round to introduce the Butterfly scheme, but she hasn’t really followed it up or done anything significant with it. I think she did the training – just telling people what it is.

Caroline – And what about Y? He’s the dementia nurse isn’t he?

Eve – I don’t know, I have never seen him. Never.

Caroline – OK I will find out who he is and I will send you his details.

After the meeting I forwarded on to Eve the information about the bathing site, and the details of the dementia CNS. In the following meeting (J2) we reviewed what had been happening since the last meeting and she had actually used some of the tips and techniques that she had read on the website.

Eve – One of the Healthcare Assistants yesterday morning, said (about a patient), “we’ll leave him until last. God it’s going to be terrible”. I said to her “It won’t be that bad. Come on we’ll go in, be positive. You get the stuff ready on the table”. So whilst she was doing that I got everything out from his locker and I was chatting to him. “Would he be willing to have a wash?” That sort of thing. “You don’t look very comfortable. I want to wash you to get you nice and warm and comfy”. And he was like, “yes, I don’t mind being warm” that sort of thing. And because of the literature I read the other day, I tried to keep him covered as much as possible.

Caroline – That was the bathing info site?

Eve – Yes. I thought right try this technique now. Because normally they do strip the top off and things. And I was like no, while we wash his face, lets keep him covered. Lets use the towel to keep him covered because that way he is not going to feel cold and tense. And she was like “oh OK”. But afterwards she was like “But he didn’t

lash out – he was absolutely lovely”. And I explained it was because he felt safe, was warm and knew what was happening. I think she did take that on board yesterday. Because she did even say to the Healthcare Assistants on the late “Oh he was lovely this morning”.

#### **Example 16 – “I didn’t realise this was so relevant” (B2)**

Bethan had identified the areas that she felt she wanted to work on during the year, but was struggling to work out how she could approach one of her staff members whom she felt was capable of much more than she was currently doing. She felt that the SN was lacking in confidence, but that this was due to the experiences she had been exposed to in the past. However, the last time she had spoken to the SN it had caused a bit of a rift between them, and Bethan was now apprehensive. I asked Bethan to look at the Person-centred Nursing framework to see how she could use it to frame her practice.

Caroline – With the person-centred care, what would you say is your first priority?

Bethan – Mine? Family and patient. I always class them as 1, because we go in to the family and client. I never just think – well the patient is always your priority – got to be – but we often, well the family are included with their teaching, because they are actually looking after the patient and you are going in and complimenting them with your care, and filling the gaps in of whatever they can provide. So that is when I see person-centred care it's the patient and family. [...].

Caroline – So where do you think this differs from patient-centred care?

Bethan – person centred is because you are including the family or the carers, [...] and person-centred care would also be the nurse that is looking after them. I need to make sure that that nurse is OK. That she is feeling happy and supported in her work. So that fits with what we have just been discussing

Caroline – Yes, so if we go to the diagram of the person-centred care framework. This is it. So these petals are you delivering care to the patients. So the things we have just been talking about, are all of these. But in order to do that you need nurses with these skills, so professionally competent – that is about having the knowledge and skills to effectively provide care

Bethan – Commitment to the job, developed interpersonal skills, knowing self, clarity of values and beliefs... oh gosh

Caroline – Yes – and that is what you need to develop in your team, because its only if you have got those that they can deliver care like that. But in addition to that, which is what you have picked up as well, to enable these nurses to deliver care like that, this care environment needs to be right as well. And if you look round that and see what is in the care environment –

Bethan – Power sharing, which is what I was saying about me handing over

Caroline – Yes

Bethan – potential for innovation and risk taking, which is what I was saying about the safeguarding and things

Caroline – Yes

Bethan – the physical environment, which would be..?

Caroline – so that would come down to things like the equipment provided and the environment

Bethan – appropriate skill mix, which is a big team thing. Shared decision-making – that is another thing that I want to develop in her. I know she can do it and I know she would get job satisfaction, and it sounds as if I am pushing her, and I’m not. But I need to develop myself. Because like you are saying, I feel as if I have let myself down, because I used to get very frustrated over the years when I worked with people that were reluctant to share their knowledge with me so that I could develop. And I don’t want to ever be like that with anybody. But in her defence, because she is so bogged down doing the bread and butter stuff there is no time to really..... OMG I didn’t realise this was so relevant....effective staff relationships – supportive organisational systems

## **“Changing our thought processes – Why can’t we have blue grass?”**

### **Example 17 – “I have forgotten about the important things” (A1)**

Annie described how she was concerned that they were failing to meet some of the service targets and what she was trying to do about this.

Annie – Every patient that comes in has (the intervention) within those 24hrs unless it’s a weekend, and then if it’s a weekend some people get missed because some people are not trained to do it. So this has been pulled up on the fundamentals of care (audit), and trying to get across, even though they have been trained, trying to get across to the nursing staff [...], that the patients need these (interventions) doing, and they are trained to do it, its just like

banging your head against a brick wall. So that is where I feel I could do better, you know. But how to go about things like that without just persistently saying, “look please you need to do this”, and telling the ward sisters there “look we are failing on this target, because of this”, and its just “Oh we haven’t got time, we haven’t got time”

Caroline – So what happens if (the intervention) doesn’t get done?

Annie – They wait until somebody can do it, and they could go over the 24hrs, and we don’t hit the targets see, so they are kept NMB with IV fluids

The second part involved a key question to change Annie’s perspective, away from the target and onto the patient, thus humanising the whole experience.

Caroline – OK, so forget the target for a minute, thinking about Mr Jones in the bed, what happens to him?

Annie – He is kept NMB and IV fluids are put up, that is what they do until someone will come along and actually perform (the intervention)

Caroline – So they don’t actually have any nutrition at all

Annie – No...., no I know

Caroline – So....?

Annie – It can be quite...., and if its late Friday evening they may not get (the intervention) until Monday morning sometimes, which is quite bad isn’t it. [...]

Caroline – So tip your thinking, if you start to look at these patients as people, and actually start to focus on the people, your targets will take care of themselves.

Annie – Yes OK

Caroline – Because you are not nursing the targets

Annie – Yes. And it is my fault because I have let it become that way, because before I had this job I was always saying “its Mr Jones, its not bed 15 or bed whatever” when I was on the ward I was always saying it, but I have left it go away.

Caroline – Why do you think that is?

Annie – I don’t know. I just think it is trying to please everybody I think, you know the managers want us to tick these boxes and get things right, and it doesn’t matter what is happening in reality, as long as we are getting the figures right

The third and final part demonstrates self-reflection and revolved around another key question, which was aimed at helping Annie critically reflect on her own practice.

Caroline – I have another question for you. If you had one of the patients on the ward you felt wasn't having his (intervention) done for an extended period of time and for some reason or other you couldn't do it, which one would you be more confident doing – going in to the (staff) room and arguing with the nurses or doctors that by not doing X, Y or Z you are not meeting this target, or going in and saying "look this patient is starving until we do something for them"

Annie – Confidence saying, I would probably say targets, which shouldn't be. I know it shouldn't be. It should be "this patient is starving", but probably saying "look we are not going to hit the target" .....yes..... um.....yes.....

Caroline – OK, and as a Registered Nurse where does your advocacy sit?

Annie – It lies with the patient, not targets ... quite true...

Caroline – So if you are not meeting targets, that is one thing

Annie – But I am not looking after patients, ...I am not looking after patients am I...

Caroline – Behind every target there is a patient, behind every number there is a patient, so every target that is not being met there is a Mr Jones on the end of it.

Annie – god yes. It makes sense now. I think I have been so fixated with all this trying to prove myself to the managers, I have forgotten about the important things.

### **Example 18 – “coming back with an idea I wouldn't have thought of” (E8)**

Emma had recognised that there was a problem with the team's way of working, and when she started to talk to me about it, this started off as a bit of a moan. Emma had been considering suggesting to the other CNS that they only undertake home visits when there were two CNS on duty. Emma and I had a conversation about the reasons for going on home visits, and what they do when they get to the patient

Caroline – So the CNS goes out and just takes his blood?

Emma – Yes she goes out and does (the intervention). She gets the results straight away so she can dose him too.

Caroline – So can't the district nurses do (the intervention)?

Emma – They have not got a machine. Some patients have their own. But he would have to buy his own machine. They are £300 so I am not sure he would want to buy his own.



Caroline – How much does it cost to send a Band 7 to do a home visit? How often do you go?

Emma – Every 10 days maybe – well 2-3 a month I would say.

Caroline – So that is 36 visits a year. How long does it take?

Emma – Well she is probably gone an hour or so

Caroline – That is £20/hour. So in actual fact in a year it is costing the NHS twice as much as it would to buy him a machine

Emma – Gosh yes

## **“Throwing the ball back”**

### **Example 20 – “How do you transfer your way of working?” (F3)**

My aim was to help Eve to recognise that she could make a significant difference to practice, but in a way that would also protect her from further criticism. In the initial meeting I sowed the seeds of being a role model and the importance of this in changing practice. Then in the following meeting we had come back to the issue and, so my key question to her was.

How do you transfer your way of working to everyone else?

And then I reminded her about our discussions in the previous meeting about influencing others and, using the idea of the ‘Circle of Concern and the Circle of Influence’, I followed this up with another ‘how?’ to get her to actually start to think about how she was putting her thoughts into action.

Caroline – And how?

Eve – And how – the how word!

Caroline – So how are you going to do it?

Eve – I don’t know. I think I’m role modelling good practice, I really try. And this communication I am trying to say “look I am doing this because...” and explaining myself a little bit more - rather than just have people say oh yes she is a good nurse she is doing it - so why I am doing it. And that is just to people in general, not just nurses... [...]

Caroline –OK so what about when working with other nurses?

Eve – It is difficult because, like you said earlier, you are working in your own little bubble. So they don’t get to see a lot. Things like the

communication with the dementia patients - I have been making a point of going in slowly, introducing myself, and doing all the textbook communication things. So hopefully others will think “she didn’t get hit”. Like I did say to the Healthcare Assistant yesterday, “its so much easier once you have calmed him down rather than trying to battle with him”. To which she did say, “well I was just trying to do my job”, and I said “I know, but we were going to get a black eye!” [...]

### **Example 21 – “What are you going to do about it? (J2)**

Jade had been heavily involved in the idea behind a new project on her ward, but due to shift patterns she had missed some planning meetings and was feeling a little bit left out of the loop. She had moved into a passive “I can’t do anything because nobody has explained it to me” mode. The intervention in this case was a direct question that required her to make a decision as to actions she was going to take. I then followed the question up by identifying a real problem that could interfere with her stated intentions, so that she could work through the reality of her situation to a concrete plan for action.

Jade – No to be honest I haven’t thought much about it at all. Because this was sent to me. And I have read it, and that is all I have done. I haven’t really done that much at all with it. But I have spoken to (ward sister). I don’t know. Because nobody has sat me down or spoken to me or anything yet I don’t know - “Oh Jade would you mind doing this?” I just presume because it says ‘gather the staff knowledge’, then that would be my role because I am the lead of the team. But no-body has actually told me...”Can you”? I don’t even know because someone could already have done that as far as I know at the moment.

Caroline – OK, so what are you going to do about it?

Jade – I need to speak to (the CNS) about it. Because I have been working... I have been off sick and I was on nights and I haven’t really had a chance to speak to her.

Caroline - But you are on nights for another 3 weeks?

Jade – I know. But I have got a day shift in one of them. I have got a study day next week, and then I am sure I have got a day shift next week. Well if not I will go in and speak to her anyway – or email her and see. Because I do need to know that don’t I. There we are – I have got Questionnaire written down on my to do list. Yes right I need to speak with (the CNS), I might even email her later. Yes

### Example 22 – “At the moment the hold up is you” (E13)

Emma was trying to get a project off the ground and had been pulling together a paper outlining her idea and investigating the possible benefits and constraints. I was aware that not much had happened with the project for a while, so I asked ‘why’ the project had stalled, and then worked with what Emma told me was the reason. This set the tone for the remainder of the encounter – there was not an option of not doing it, it was simply working out a way that she *could* do it.

Caroline – So what is happening to your project?

Emma – Nothing, since I spoke to you last [...] I haven’t done anything to it. It is at a standstill at the moment.

Caroline – Why?

Emma – Honestly? Because I think it’s something that I will have to do at home, and I just don’t do anything at home work-related. I don’t feel I have the time.

Caroline – OK. So it has to be done in work.

Emma – Yes it has to be done in work

Caroline – So what have you got to do to it?

Emma – Summarise it basically. We were going to put it into bullet points and condense it down. And circulate it to various people for their opinions [...]

Caroline – So it is not a lot of work [...] What are you going to do?

Emma – (Sigh) Everything and nothing probably. Everything here is the plan, but.... [...]

Caroline – The only way it is going to happen is if you pull your finger out and get on with it

Emma – Yes it’s true, it’s true. And for about a week after our meeting I am full of good intentions

Caroline – OK so this week then, and do it [...]

Emma – You want me to do this in work?

Caroline – Yes. Even if you come in to work half an hour early on those four days that you work. That would give you two hours

Emma – Yes

Caroline – Bullet point it up and send it out. It might not be perfect, but that is why you are sending it out for people to comment on.

Emma – OK

Caroline – If you don't get on with it, it will disappear

Emma – Which is kind of what I am hoping it will do (laughs)

I tried to inject some positivism back into things by telling her how important the project was, and also the name of another person who might be able to help take it forward. I also set a deadline for the work because I felt we were at a critical stage and the project needed some external driving.

Caroline – I did a course at the end of last week [...] with Community Nurses and I mentioned this to them and they were absolutely thrilled to bits at the thought that something like this is possible. [...] They were really keen on the idea. And I have been given another name of someone who might be someone to contact. [...] And she apparently has access to a pot of money for “spend to save”, so that you can spend some money in order to save money, and that this might be able to come in to that. So it needs you to get on with it so you have got something to actually start sending to people. Because at the moment the hold up is you [...]

Emma – Me. I know, I know. OK

Caroline – So, you are enthusiastic for the week after I have been – sort it this week, and email it to me before I go away [...]

Emma – OK, I shall try

Caroline – I need it by then

Emma – When is that?

Caroline – 16<sup>th</sup> and we are on the 6<sup>th</sup>. OK that is 10 days. And I will send it back to you with some feedback and then you can send it out to people and ask them to comment.

Emma – (writing it in her diary)

In the process review at the end of the session I told Emma that I was really tempted to tell her to let me finish it. I did this because I wanted her to understand the importance of the project, but also to help her see that it couldn't go away. In view of her previous comment that she was hoping it would disappear, it was also to give her the potential to actually withdraw should she really need to. Her refusal to let me finish the project I took as a good sign as it indicated that she was still feeling ownership.

Caroline: In actual fact what I am fighting is the desire to say “give it to me and I'll do it”

Emma: Don't do that

Caroline: No?

Emma: No don't do that. I would love you to do that, but that would sort of defeat the whole point of me learning and developing wouldn't it

Caroline: Absolutely

Emma: So don't do that. As much as I want you to - don't - because that is just a complete cop out for me.

Caroline: It's a cop out for me as well

Emma: But I know what you mean. Its like when I am in work I am in work frame of mind. Get on with whatever I have got the time to do in that day. And come the time that I walk out the door I'm not the specialist nurse anymore

Caroline: And that is why I say, come in half an hour early, go up to that office upstairs so you don't have to see everyone else, and just use that time. So you don't have to take it home with you. Because it's potentially easier at the beginning of the day

Emma: Yes definitely. And I could potentially do that. I am willing to do that, but I am not willing to pay extra for crèche, so I am not willing to take my son early into crèche to do that, but there are times in the week when I don't have to. So I could have a look at doing that maybe tomorrow even. OK

## **7C. Theme 4 - Outcomes**

### **Outcome example 2 - "I feel that I have stuck up for the patient" (E11)**

As Emma had developed she was getting used to 'thinking differently'. This was manifest in the following incident.

Emma - The ward called me up there and said the Dr wants to start this 91 year old lady on (drug). And I said fine I'll come and do some counselling. "Oh she is not very keen to go on to (drug)", so I said Oh right OK. So they said "can you just come up and have a chat with her and just basically see if you can talk her round". And I thought yes right I can come up and have a chat with her about it. And I said to the girls in the office this morning "I have got to go up to the ward to see this lady, to see if I can persuade her to go on to (drug)", and as I said it I thought 'why would I want to persuade a 91yr old to go onto (drug) if she doesn't want to go onto it?'. So I got up there and I started talking to her [...]. (Emma explained the pros and cons of the suggested treatment to the patient). [...] So as I was writing in her notes, I thought Emma, stop writing this, you shouldn't be writing this. But I had given her all the information, I said to her that "you make the decision you are most comfortable with, but all I am concerned about is that you have had all the

relevant information in order that you can make that decision”. So I gave her all of that, and I wrote in the notes all of that, and at the bottom I wrote “In view of this ladies age and the effect that (drug) would have on her lifestyle ie. Travelling and frequent blood tests (or something like that), I don’t wholly disagree with her being so cautious”. So I have put that in her notes now.

Caroline – How do you feel about that?

Emma –I am quite pleased because I feel that I have stuck up for the patient, and what is in the patient’s best interest. [...] So partly I am sort of pleased, but now I think maybe I have put myself out on a limb a little bit. [...] I haven’t said I don’t think this lady should go on (drug), but I have just put my cautiousness there as well. [...]

Caroline – And I think well done you! No I seriously do. Because I think what you have demonstrated by doing that is you have confidence in yourself, you have confidence in your own ability to make a decision and I think that is a fabulous step forward. You wouldn’t have done that 7 months ago

Emma – No I wouldn’t

## Practitioner Flourishing

### Eve's initial vision



For years, because of having children and what not, I feel as if I have been stagnant, almost like a seed. Just not done anything. And then when I have tried in the past to develop I have got stuck amongst the weeds and not got very far. But I have got to a point where I really want to go somewhere now. I have got to get a sense of direction and achieve something. I know it is going to be stormy on the way, lots of other issues. But I don't want to get lost like a little butterfly fluttering around. I want to aim a bit higher and encompass other people along the way, and help spread things that I learn and nurture others as well. [...] So that is not the real me that is on this ward at the moment. I go into work, I do my job and that's it. But I am not who I am, [...] and I want to come across, to come back – because I am quite a confident and bubbly sort of person normally – so I want to go back. Rather than just coming in and ticking over. [...] I am hoping to be happier. Because at the moment I am not [...] I just don't feel that I have anything to grasp and hold on to, and to work for. I am just ticking over in this everyday stuff. (Eve - Creative visioning)

## Melanie's Initial Vision



"I asked myself where do I want to be in a year, what do I want to achieve in a year, and where do I see myself personally in a year. So this is the first picture I came to which is this three-headed person, which symbolises those three questions that I asked myself. So pointing towards where do I want to be in a year, I see myself as wanting to have a structure, but not a firm structure which is why

I did wiggly lines on the side so that it's a moveable structure but with structure inside it, which is where the squares inside came. A structure of my week, a structure of my role, I just feel that everything is so unstructured at the moment. And I understand that it needs to be flexible, but I need to have that feeling that, I suppose it is a control as well isn't it. With realistic aims within that structure as well. Confident in my role, which is where that lady comes in because she looks very confident. And with the confidence in my role comes the link and the resource within the Trust [sic]. And then looking at what do I want to achieve in one year, I want to become a role model, so that's a roll and that's a model. And to have a work / life balance which is that – its meant to be a see-saw - so that there is a good work/home life balance because at the moment I feel as if it is all engulfing my brain and my children and my husband are suffering a little bit because I am all just constantly stressing about it. Developing continuously was this, so starting off with the little flower and then becoming the developed flower within the year hopefully, but also it's a continuous process. So when I first set it out I did it with 2 flowers, continuously growing, because it is not something that is going to come to an end when the flower blooms, it will keep going. To be the facilitator of staff development and which will in turn improve patient care, and patient-centred care – individual patient centred care which was where this came in. So this was less waste of time and energy that the nurses on the wards are giving at the moment, without the reward because you are not seeing any benefit, or very little benefit for the amount of effort that is put in. And the bit that I am missing is the setting up of a new service, and I wasn't sure how I was going to illustrate that one, so in the end I just put an arrow and service above it".



## Emma's Initial Vision



“This symbolises what I would hope for over the course of this study. This person obviously symbolises me, and the footsteps are just a path that I have taken to get to this place. Arms reached out, reaching for the stars, and a new moon because it is all new stuff that I am reaching for, things that I haven’t attained yet. And the tree here is the tree of growth and knowledge, which is what I am aiming for really. I haven’t yet decided yet... what.... If there is anything specific that I am hoping to attain, but it is all really about me growing personally and professionally I think. And the flowers on the tree then are what I have here that I am scattering out. Hopefully I will be a good role model and sort of spread what I have learnt to other people.”

## Possible Negative Outcomes

### Outcome example 7 - “Living in a parallel universe”

I asked the practitioners what they had liked least about participating in the study

Melanie – What have I not liked, the only thing I can think of, because I found it all a massively positive experience for me, but the only thing I can think of with a slight negative connotation is the feeling of being - and I know we have discussed this outside of this session - is the feeling of being on a parallel universe to the majority of other nurses that I am working with, or managers, and the feeling that I am talking a different language to everyone else. And that I feel like I’m on my own sometimes when I am being motivated and enthusiastic and wanting to make change for the better. And although that is not a negative, it makes me question myself a lot more. Question am I just thinking like a nutter, and should I just go back to them? That’s how I feel. Does that make sense?

Me – Yes. So the question then I suppose is, because what I said was what about it have you liked the least? So it is the fact that, by the work that we did together that put you into that parallel universe, and if we hadn’t been doing that work together the chances are that you wouldn’t have been in that space.

Melanie – Yes. I would have still been back (where I was before) absolutely. It has put me in a different place in my thought processes than I have ever been before and if we hadn’t have spent the last year together I am not sure I would be where I am now. And that creates - is that because I am out of my comfort zone, because I am constantly challenging my practice, and the practice of others and the service we are providing - constantly. Like the discussion we had just now when I was questioning facilitation and does it have to be a nurse. I never used to be like that, I never used to have those questions, I used to think I had the answer and say well actually no we do and that is that, but now there is no answer, and there are constant different choices and questions. And it can make you go a little bit stir crazy. It can make me go a little bit crazy, and I am not sure that that is necessarily good or bad, I don’t know.

## Appendix 8 – Research Training

<i>Research Training Undertaken</i>			
PhD level academic module	Course 501 – The Science and Practice of Person-centred Research [ECTS 15]	Faculty of Health Sciences Buskerud and Vestfold University College, Norway	2014 Sept - 2015 Feb
Short Courses & Study Days:	Advanced Practice Development School (5 days)	Canterbury	2013 - September
	Action Research Course (2.5days)	University of Ulster	2013 - June
	International Symposium on Person-Centredness in Nursing Education (2 days)	University of Ulster	2013 - May
	Searching for Evidence (1 day)	National Institute for Social Care and Health Research (NISCHR)	2012 - December
	Action Research (2 days)	University of Stavanger, Norway	2011 - December
	IRAS workshop (½ day)	Hywel Dda Health Board, Wales	2010 - October
	Action Research Study Day & Masterclass (1 day)	University of Ulster	2010 - April
Face:Face training (1:1)	Literature searching & use of RefWorks	Life & Health Sciences Assistant Librarian, University of Ulster	2010 - January
On-line courses	Research Integrity	University of Ulster	2012 - August
	Ethics 1 - Good Research Practice	EPIGEUM	2010 - February
	Ethics 2 - Working with Human Subjects		

	Literature Review		
	Managing your Research Supervisor		
	Research Project Management		
Research week:	Individual consultations with visiting professors (Prof. Angie Titchen; Prof. Jan Dewing) Lunchtime seminar Doctoral student’s conference Masterclass – Knowledge & Expertise	University of Ulster	2012 - May
Community of Practice:	Action Research / Practitioner Research Community of Practice Meetings	Queen Margaret University, Edinburgh <b>Presentation:</b> The Black Whole – valuing the shadowed side	2016 - April
		Queen Margaret University, Edinburgh	2015 - Sept
		Buskurud University, Drammen (Norway)	2013 – November
		University of Ulster	2013 - March
		Christ Church University, Canterbury	2012 - November
		University of Ulster	2012 - April
		University of Ulster	2011 – November
		University of Ulster	2011 - March
		University of Ulster	2010 - Dec
<b><i>Publications in Peer Reviewed Journals</i></b>			
Williams C (2012) Working with relationships and boundaries. Part 2 – Setting boundaries. <i>International Practice Development Journal</i> . 2 (1) 10			
Williams C (2012) Working with relationships and boundaries. Part 1 – Developing relationships. <i>International Practice Development Journal</i> . 2 (1) 9			
Williams C (2010) Understanding the essential elements of work-based learning and its relevance to everyday clinical practice. <i>Journal of Nursing Management</i> 18(6) 624-632			

<i>Conferences Attended</i>		
<i>Enhancing Practice Conference, Edinburgh</i>	<b>Poster Presentation</b> “The joy and challenge of using Critical Companionship as a research methodology” <b>Oral Presentation</b> “Why can’t we have blue grass?” Helping nurses to learn through their work	2016 - September
<i>International Reflective Practice Conference, Swansea University</i>	<b>Oral presentation</b> “The Role of Facilitation in Enabling Work-based Learning”	2013 - September
<i>STTI Phi Mu Chapter Conference, Bournemouth University</i>	<b>Oral presentation</b> “The role of facilitation in enabling work-based learning”	2013 - June
<i>Chief Nursing Officer (Wales) Annual Conference, Cardiff</i>	<b>Oral presentation</b> “Facilitating Nurses To Learn Through Their Work - The Impact On Practitioners And Their Practice”	2013 - May
<i>CARN/IPDC Student Conference, Canterbury Christ Church University</i>	<b>Oral presentation</b> "Developing Critical Companionship as a methodological framework for a participative action-oriented research study"	2012 - November
<i>CARN/IPDC Conference, Canterbury Christ Church University</i>	<b>Oral presentation</b> "Working with relationship and boundaries"	2012 - November
<i>Research conference "Conversazione" Swansea University</i>	<b>Poster presentation</b> "The role of facilitation in enabling work-based learning" - Proposal	2011 - November
<i>Enhancing Practice Conference, Belfast</i>	<b>Oral presentation</b> “From teacher to facilitator – A journey of personal growth, discovery and becoming”	2010 - September
<i>Seminars Given</i>		
Queen Margaret University, Edinburgh	<b>Seminar</b> ‘Lighting a flame: facilitating nurses to learn through their work’ - Progress	2015 - March
Swansea University, Swansea	<b>Seminar</b> ‘Facilitating nurses to learn through their work’	2018 - October

## Appendix 9 – Publications

The following publications have come from or are related to this thesis.

### 9A. Williams C & McCormack B.,2017

Williams C & McCormack B., (2017) Learning to be an effective person-centred practitioner. Chapter 14 in McCormack B, van Dulmen S, Eide H, Skovdahl K and Eide T.(Eds.)(2017) *Person-Centred Healthcare Research*. Wiley Blackwell: Chichester pp169-180

### 9B. Williams, C., 2012.

Williams, C., (2012a) Working with relationships and boundaries: Part 1 - developing relationships. *International Practice Development Journal*. vol. 2, no. 1, article 9.

### 9C. Williams, C., 2012.

Williams, C., (2012b) Working with relationships and boundaries: Part 2 - setting boundaries. *International Practice Development Journal*. vol. 2, no. 1, article 10.

### 9D. Williams, C., 2010.

Williams, C., (2010) Understanding the essential elements of work-based learning and its relevance to everyday clinical practice. *Journal of Nursing Management*. vol. 18, no. 6, pp. 624-632.